

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00811

1. DECEASED-NAME (Type or print)		First Middle Last WALTER ALEXANDER		2a. DATE OF DEATH Month Day Year JANUARY 17, 1968		2b. HOUR 8:30 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10/25/76		6. AGE (In years last birthday) 91 YRS.	
7a. BIRTHPLACE (State or foreign country) U.S.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER Md.	
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MO.		13b. COUNTY CAR.		13c. CITY OR TOWN PRESTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last ALBERT ALEXANDER		15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491x</u> <u>Branchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic bronchitis and emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5020</u> Approximate interval between onset and death <u>2 days</u> <u>5 years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 31, 1967</u> , to <u>January 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>January 17, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Carlos F. Barroso MD</u> DEGREE				22c. DATE SIGNED <u>January 17, 68</u>			
22d. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO MD</u>				22e. ADDRESS <u>HURLOCK MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 20, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Near Preston, Maryland</u>	
24. FUNERAL DIRECTOR <u>J. J. Thompson & Son Funeral Home, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>JAN 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-200

11-200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00812										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00812																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
Elizabeth Jane Bell										Jan. 16 1968										5:40 PM																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										7. IF UNDER 1 YEAR										8. IF UNDER 24 HRS.																													
Female										White										Sept. 29, 1877										90 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
Md.										U.S.A.																				Norchester																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Hurlock, Md 21643										Belle Haven Nursing Home										Housewife																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																																							
Md.										Somerset										Hurlock																																																											
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
John Phillip Hoffmann										Mary Ann Naughterty																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
No										217-54-5906										Mrs. Anna B. Wall										R.F.D. Marion Station,																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I. DEATH WAS CAUSED BY:																																																																															
403 X IMMEDIATE CAUSE (a) Uremia										3 days																																																																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 446 X										DUE TO, OR AS A CONSEQUENCE OF (b) Benign Arteriole Nephrosclerosis										5 years																																																											
										DUE TO, OR AS A CONSEQUENCE OF (c)																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
Senility																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from February 7, 1967, to January 16, 1968, that (I) (we) last saw the deceased alive on January 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED																																																																					
Carlos F. Barroso MD										January 16, 1968																																																																					
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
CARLOS F. BARROSO MD										Hurlock Md																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										Jan. 19, 1968										Rehobeth Meth. Cemetery										Rehobeth Somerset Md.																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Levin R. Wilson - Somerset County, Md.																				DATE JAN 22 1968										Charles Judge																																																	

MEDICAL CERTIFICATION

00812

00819

Robert F. Johnson
Contractor
219-24-2900
No

Handwritten notes and signatures, including a signature that appears to be "Robert F. Johnson".

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VR 115-14
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) MAGDALENA WEHRLE BELL						2a. DATE OF DEATH Month Jan Day 3 Year 1968		2b. HOUR 8 4 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 10, 1890		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 304 Belvedere Avenue				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 304 Belvedere Avenue			
14. FATHER'S NAME First August Middle Last Wehrle				15. MOTHER'S MAIDEN NAME First Magdalena Middle Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-05-7799		17. INFORMANT Address Mr. Jos. Kerr, 304 Belvedere Ave., Cambridge Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) Anticoagulant therapy DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4331										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary Cholelithiasis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1967 to Jan 3, 1968 , that (I) (we) last saw the deceased alive on Jan 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. U. Thompson, M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 1/4/68			
22d. PHYSICIAN'S NAME (Type) J. U. Thompson, M.D.				22e. ADDRESS Locust St., Cambridge, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 6, 1968		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR H. H. Witzke & Sons, Baltimore, Maryland				25a. REC'D BY REGISTRAR DATE JAN 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

00817

RECEIVED

DATE

TIME

NO.

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VR A (M)
30M REV 1/68

00814												00814											
1. DECEASED-NAME (Type or print) First Middle Last												2a. DATE OF DEATH Month Day Year						2b. HOUR M					
GUSTAVUS ADOLPHUS BROWN												JANUARY 17 68											
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
MALE			WHITE			02-12-77			90														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH														
MARYLAND			USA						DORCHESTER Md.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY											
CAMBRIDGE			EASTERN SHORE STATE HOSP						UNEMPLOYED														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER												
MARYLAND			TALBOT			EASTON			YES		7 PLUM STREET												
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last																	
ALDOLPHUS BROWN						LOUISA ANNE THOMAS																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT Address																	
			579-05-1654A			RECORDS OF THE EASTERN SHORE STATE HOSPITAL																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY:												3 days.											
IMMEDIATE CAUSE (a) Pneumonia																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 493A																							
DUE TO, OR AS A CONSEQUENCE OF																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from April 19, 1963, to January 17, 1968, that (I) (we) last saw the deceased alive on January 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Carlos F. Barroso MD						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED January 17, 1968														
22d. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO MD						22e. ADDRESS Hurlock Md (Dorchester)																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)														
Burial			Jan-20-1968			ST. JOHN'S CEMETERY			Deal Island Somond														
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Heroy G. Webster Princess Anne									DATE JAN 23 1968			M. J. Judge											

MEDICAL CERTIFICATION

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CONFIDENTIAL

2392 J. Neurosci., September 24, 2008 • 28(39):2387–2395

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25. 41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-106

1. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2618. 2619. 2620. 2621. 2622. 2623. 2624. 2625. 2626. 2627. 2628. 2629. 2630. 2631. 2632. 2633. 2634. 2635. 2636. 2637. 2638. 2639. 2640. 2641. 2642. 2643. 2644. 2645. 2646. 2647. 2648. 2649. 2650. 2651. 2652.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

00815

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00815

| | | | | | | | | | | | |
|---|--|---|---|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(Type or print) William Henry Burke | | | 2a. DATE OF DEATH
Month Jan. Day 19 Year 1968 | | | 2b. HOUR
11 AM | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 1, 1877 | | 6. AGE (In years last birthday)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | | |
| 7a. BIRTHPLACE (State or foreign country)
Ann Arundel | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cambridge-Maryland Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Carpenter Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY
Dorchester | | 13c. CITY OR TOWN
Linkwood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Route 50 | | |
| 14. FATHER'S NAME First Frank Middle Last Burke | | | 15. MOTHER'S MAIDEN NAME First Carolyn Middle Last Davis | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
213-01-7985 | | 17. INFORMANT Address
Miss Edna P. Burke, Linkwood, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 485X Bronchopneumonia, bilateral
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18/68 , 19 68 , to 1/20/68 , 19 68 , that (I) (we) lost saw the deceased alive on 1/19/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Alfred R. Maryanov | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/20/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV | | | | | | 22e. ADDRESS
610 RACE ST, CAMBRIDGE, MD | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | | 23b. DATE
Jan. 21, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park, Cambridge, Md. | | | 23d. LOCATION (City or Town) (County) (State)
Cambridge, Md. | | | |
| 24. FUNERAL DIRECTOR
Alfred R. Maryanov | | | | | | ADDRESS
Cambridge, Md. | | 25a. REC'D BY REGISTRAR
DATE JAN 24 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1860

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--------|-----------------|--|--------------------------------|-----------------------------------|---|--|--|--|---------------------------|---|------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First | Middle | Last | 2a DATE KNOWN
OF ESTI-
DEATH MATED | | | Month | Day | Year | 2b H.O.J.R.
M |
| Hubert | | | Washington Cephas | | | 1-20 | | | 19 | 68 | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years
last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c DATE PRONOUNCED DEAD
Month Day Year | | | 2d HOUR | |
| Male | Negro | 3/1/1914 | 53 YRS | | | | | 1 20 1968 | | | 2-15 | |
| 7a BIRTHPLACE (State or foreign
country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| Md. | | | USA | | | | | | Dorchester Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR
INDUSTRY | | | |
| Cambridge | | | Cambridge Md. Hospital | | | Farmer | | | Farm | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institut on- Residence before
admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| Md. | | | Dor. | | | Cambridge | | | 631 High St. | | | |
| 14 FATHER'S NAME | | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | | First | Middle | Last | |
| Edward Brown | | | | | | Mary E. Cephas | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | ADDRESS | | | |
| Yes | | | WW 2 | | | 213-16-8976 | | | Elizabeth Cephas 631 High St. 21613 | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple injuries, severe
DUE TO, OR AS A CONSEQUENCE OF
(c)
(d) | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 hrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 8124 | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 9b CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20 AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M.
7:15 P.M. 1/2/68 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part or Part 2, item 18)
Hit by hit and run driver. | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | 21e PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
Street | | | 21f LOCATION Street or R.F.D. No City or Town County State
Chesapeake ct. Cambridge, Dor., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | EXAMINER'S
NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b DATE SIGNED
1/23/68 | | | |
| John Mace Jr. M.D. | | | | | | ADDRESS (Street, city, town, or county) | | | Cambridge, Md. | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 1/25/68 | | Waugh Cemetery | | | Cambridge, Dor., Md. | | | | |
| 24 FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Felix C. Mace | | | | | | Cambridge, Md. | | DATE JAN 30 1968 | | Felix C. Mace | | |

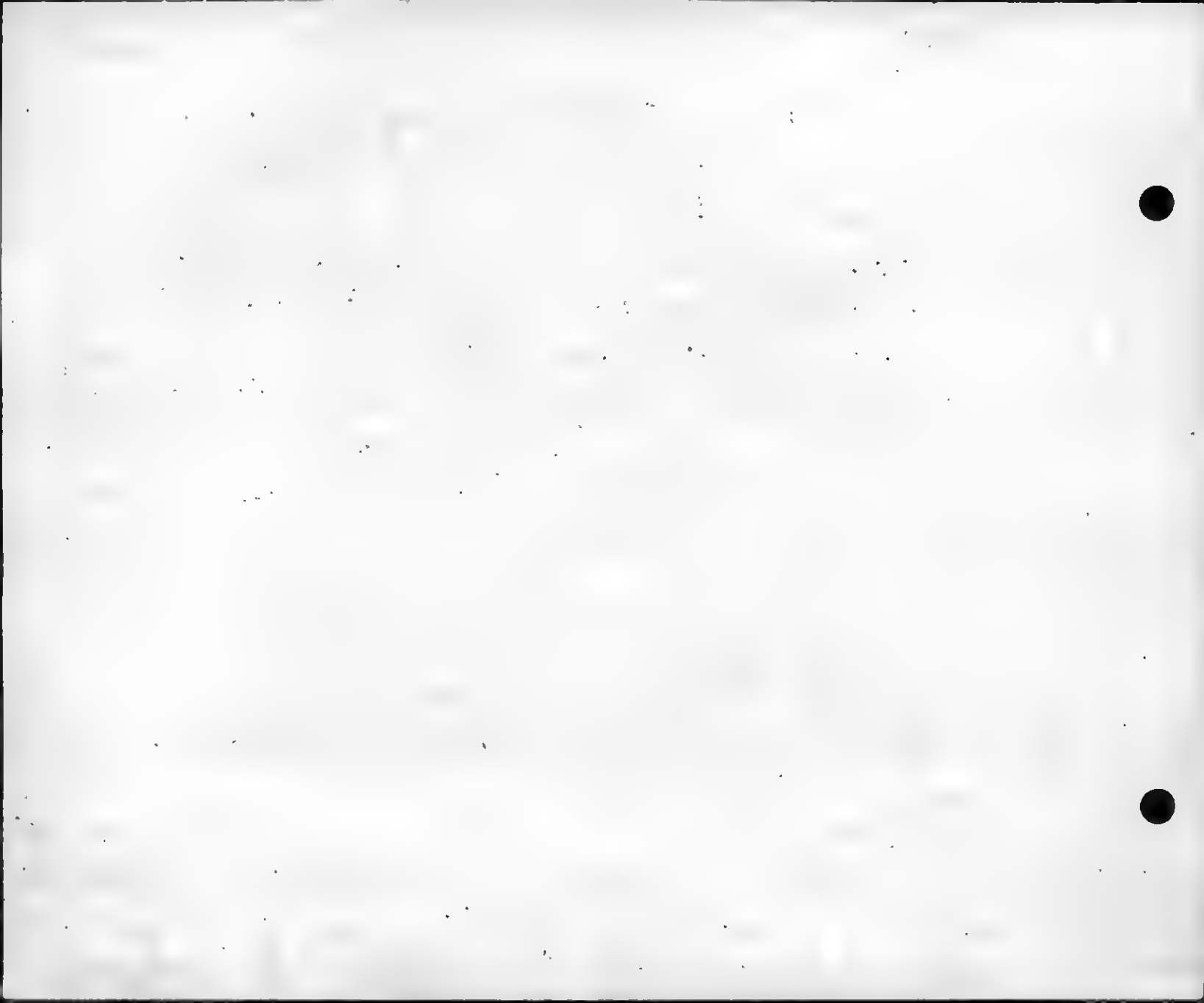


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15 (4)
30M REV. 7/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|--|---------------------------------|--|--|--|------------------|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| HANS | | | J. CHRISTIANSEN | | | Month 1 Day 2 Year 68 | | | 4:30 A.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| male | | white | | 7/24/1883 | | | 84 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | |
| Denmark | | | Denmark U.S.A. | | | | | | Dorchester | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cambridge | | | Eastern Shore State Hosp. | | | Merchant Marine | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. since before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Maryland | | | Worcester | | | Pocomoke City | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Route # 3 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| HANS | | | CHRISTIANSEN | | | UNK. | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| Yes - Merchant Marine | | | 090-14-4170A | | | Eastern Shore State Hosp. (Med Records) | | | Cambridge, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY. | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic heart disease</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis</i> | | | | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| 14 days | | | | | | | | | | | | | | |
| YEARS | | | | | | | | | | | | | | |
| YEARS | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| <i>Chronic brain syndrome</i> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION | | | Street or R.F.D. No. | | | City or Town | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 4, 1967</i> , to <i>January 2, 1968</i> , that (I) (we) last saw the deceased alive on <i>January 2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DEGREE | | | 22d. ADDRESS | | | 22e. DATE SIGNED | | | | | |
| <i>Leandro M. Area M.D.</i> | | | M.D. | | | <i>Eastern Shore Hosp. Cambridge, Md.</i> | | | <i>January 2, 1968</i> | | | | | |
| 22a. PHYSICIAN'S NAME (Type) | | | 22b. ADDRESS | | | | | | | | | | | |
| LEANDRO M. AREA | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 1-4-1968 | | | FIRST BAPTIST | | | POCOMOKE CITY - WOR. - MD. | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. RECD BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <i>Robert N. Watson</i> | | | <i>Pocomoke City, Md.</i> | | | <i>JAN 8 1968</i> | | | <i>John Charles Judge</i> | | | | | |
| <i>ROBERT N. WATSON</i> | | | | | | | | | | | | | | |

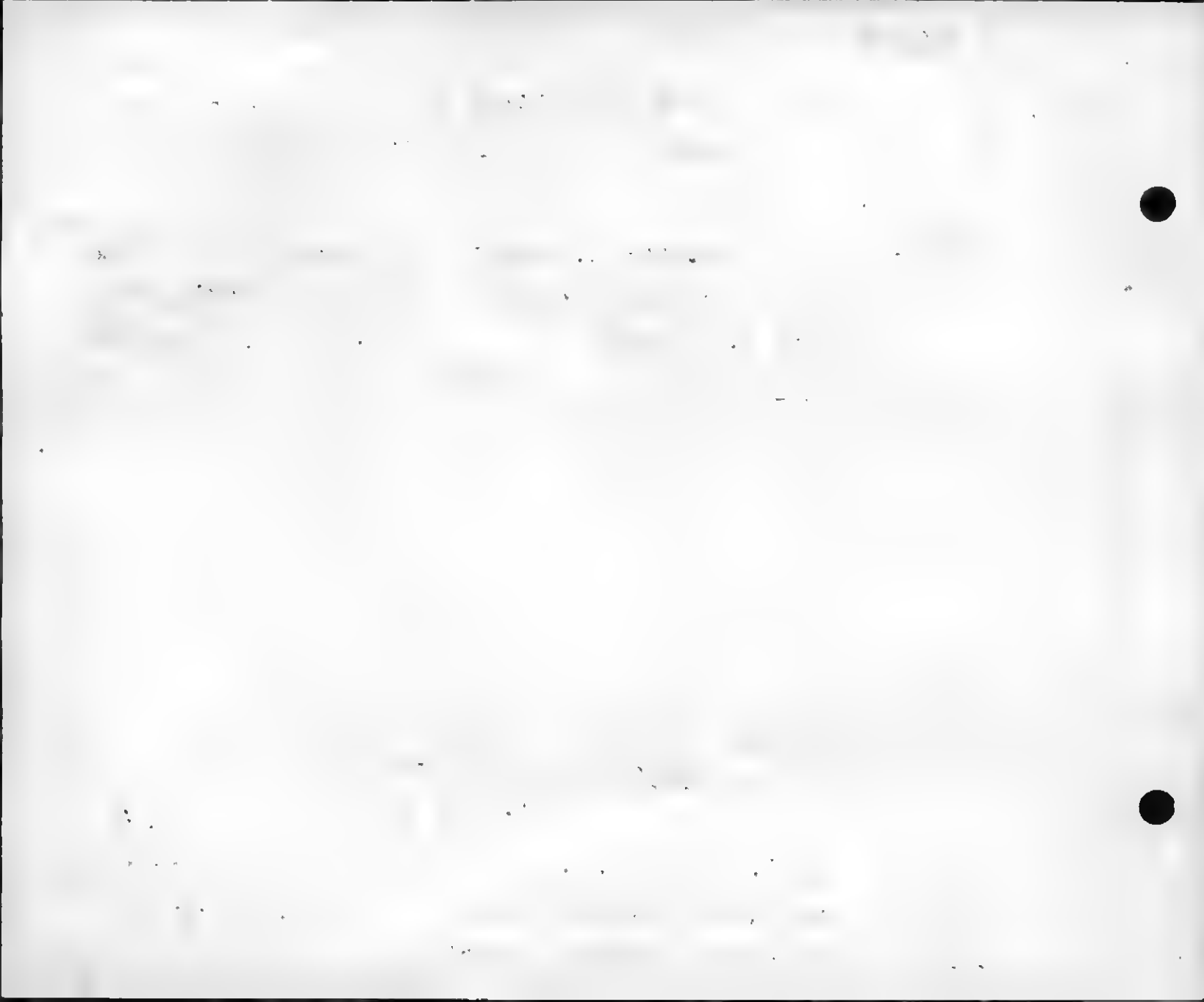


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME (Type or print)
First ALICE Middle WRIGHT Last CLAYTON | | | | | | 2a. DATE OF DEATH
Month Jan. Day 22 Year 1968 | | | 2b. HOUR
11:55 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
May 20, 1902 | | | 6. AGE (In years lost birthday)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cambridge Md. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
210 Glenburn Avenue | | | | |
| 14. FATHER'S NAME First William Middle S. Last Wright | | | | 15. MOTHER'S MAIDEN NAME First Linda Middle ? Last Fountain | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
unk | | 17. INFORMANT Address
Mr. Ellison R. Clayton, Cambridge, Maryland | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
162.1 IMMEDIATE CAUSE (a) Bronchogenic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
162.1 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/2/1967 , to 1/22/68 , 19 68 , that (I) (we) last saw the deceased alive on 1/22/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Alfred R. Maryanov | | | | M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/23/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Alfred R. Maryanov, M. D. | | | | 22e. ADDRESS
610 Race St., Cambridge, Md. 21613 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Cambridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Cambridge, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE JAN 29 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00819 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film G396 1/12/68
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00819

| | | | | | | | | | | | | | |
|---|--------|---|--|---|--|--|--|---|--|--------------------------|-----|--|--------------------------|
| 1. DECEASED NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month | Day | Year | 2b. HOUR
8:45
A.M. |
| LUELLA | | MORRISON | | DICKIE | | | | <input checked="" type="checkbox"/> JAN. 8 1968 | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (in years
last birthday) | | F UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| FEMALE | WHITE | 1/13/75 1874 | | 93 YRS | | | | | | Month Day Year | | 19 M | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | Md | |
| LOVA SCOTIA | | U.S.A. | | | | DORCHESTER | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| RURAL CAMBRIDGE | | EASTERN SHORE STATE HOSPITAL | | HOUSEWIFE | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| MD. | | CECIL | | BETTERTON | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | |
| ROBERT MORRISON | | | | ACKSA REIO | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | | | 216-54-9770T | | HOSPITAL RECORDS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONIA, TERMINAL</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>FRACTURE OF RIGHT FEMUR</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>47</u> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 DAYS
7 WEEKS | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
? P.M. Nov. 17 67 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
FELT IN HOSPITAL | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
HOSPITAL | | 21f. LOCATION Street or R.F.D. No
CITY OR TOWN
CAMBRIDGE, MO. | | | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE <u>John Mace, Jr.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
1/8/68 | | | | | |
| EXAMINER'S
NAME (Type) JOHN MACE, JR. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | 1-10-68 | | Still Pond Cemetery | | Still Pond Kent Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Victor M. Kennedy | | Still Pond Md. | | JAN 10 1968 | | Charles Judge | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00820

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00820

| | | | | | | | | | | | | | |
|--|------------------------|------------------------------------|---|--|--|---|--|---|---|--|---------------|--|--|
| 1 DECEASED NAME
(Type or Print) Blanche Catherine Fosmyer | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH
EST. <input type="checkbox"/> MONTH DAY YEAR
MATED <input type="checkbox"/> 1-7-1968 | | | 2b. HOUR
M | | | | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
01-27-81 | 6 AGE (in years last birthday)
86 YRS | F UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | I UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 1 Day 7 Year 1968 | | | 2d. HOUR
M | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Dorchester | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Eastern Shore State Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housework | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | |
| 13a. USJA. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
Maryland | | | 13b. COUNTY
Queen Anne's | | | 13c. CITY OR TOWN
Centreville | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
402 Water St. | |
| 14. FATHER'S NAME
Joseph Fosmyer | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
Mary Catherine Harper | | | First Middle Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
217-54-5369 | | | 17. INFORMANT
Eastern Shore State Hosp. Cambridge Md. | | | ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493x
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WK. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
GENERALIZED SEVERE ARTERIOSCLEROSIS, COLLES FRACTURE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
1:30 AM JAN 5 1968 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
FELL ON FLOOR. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
TAWES BLDG. (ESS.H.) | | | 21f. LOCATION Street or R.F.D. No
CAMBRIDGE | | | City or Town
DOR. MD. | | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John Mace Jr. | | | EXAMINER'S NAME (Type)
JOHN MACE JR. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
JANUARY 9, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Chesterfield Cemetery | | | 23d. LOCATION (City or Town)
Centreville, D.A.Co., Md. | | | (County) (State) | |
| 24. FUNERAL DIRECTOR
James H. Bunting Jr. - Bunting Bros., Centreville, Md. | | | ADDRESS | | | 25a. RECD BY REGISTRAR
JAN 9 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Gage | | | | |

A 30

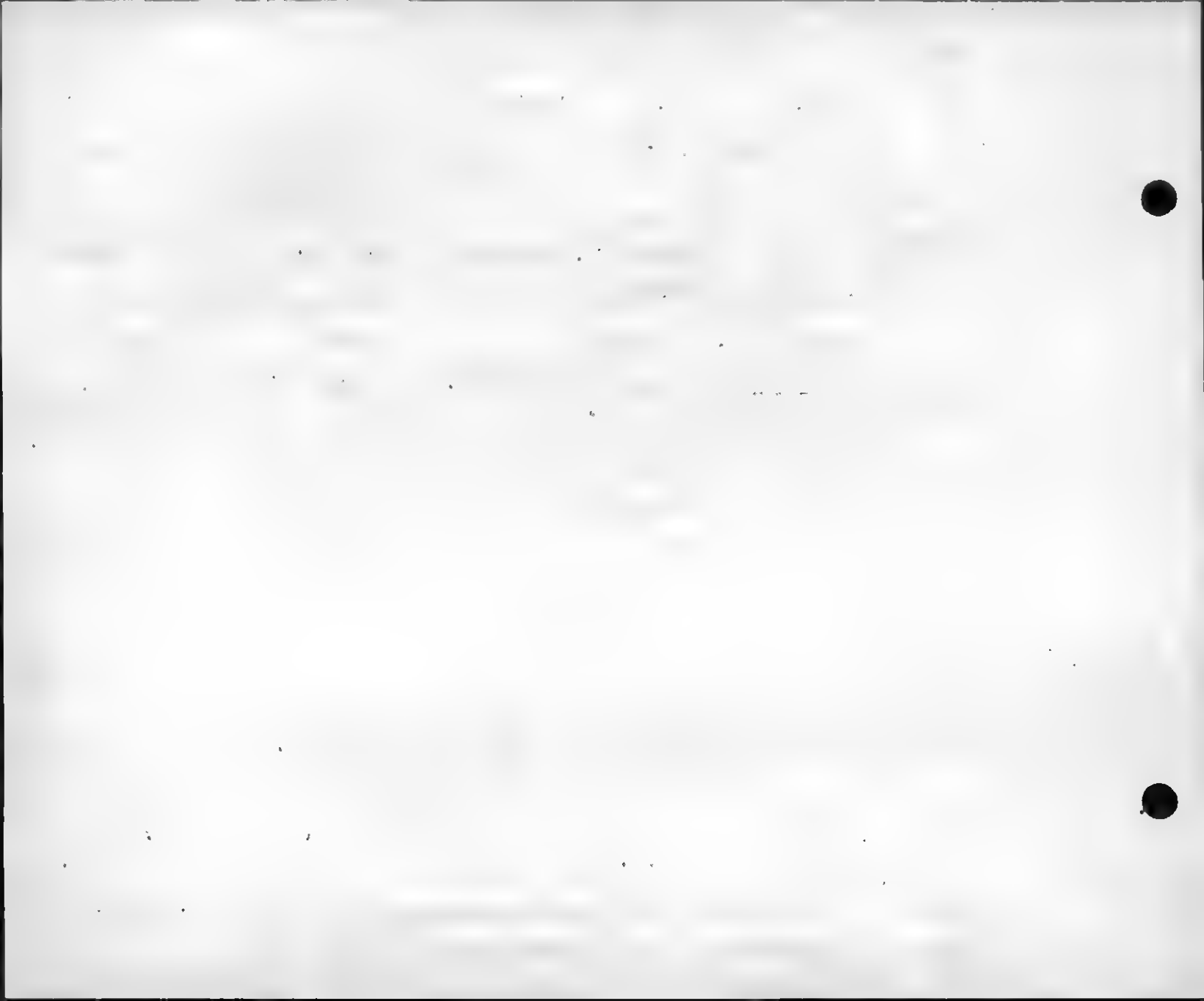


FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--------|-----------------------------|---|--|-----------------------------------|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN
OF ESTI-
DEATH MATED | | 2b HOUR | |
| CHARLIE H. FLOWERS | | | | | | Jan 27 19 68 | | M | |
| 3. SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER 1 YEAR
MONTHS DAYS | 8 IF UNDER 24 HRS
HOURS MIN | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | Mar. 11, 1886 | 61 YRS | | | Jan 27 19 68 | | M | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Dorchester | | Md | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Cambridge | | | Cambridge Md. Hospital | | | Waterman | | Seafood | |
| 13a USJA. RESIDENCE (Where deceased lived, if institution Res. before adm. ssion) STATE | | | 13b COUNTY | | | 13c. CITY OR TOWN | | 13d INSIDE CITY LIMITS? | |
| Md. | | | Dorchester | | | Fishing Ck. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | |
| First Middle Last | | | First Middle Last | | | None | | | |
| Alfred T. Flowers | | | Carrie ? Smith | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | ADDRESS | |
| No | | | None | | | Mrs. Ch. H. Flowers, Fishing Creek, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 Mins. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
42 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| | | | 19 | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCAT ON Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | 1/29/68 | | | |
| John Mace Jr. M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | Cambridge, Md. | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | |
| Burial | | | Jan 30 1968 | | Hosier Memorial Cemetery | | Fishing Creek, Maryland | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| LeCompte Funeral Service, Cambridge, Maryland | | | | | | JAN 30 1968 | | | |

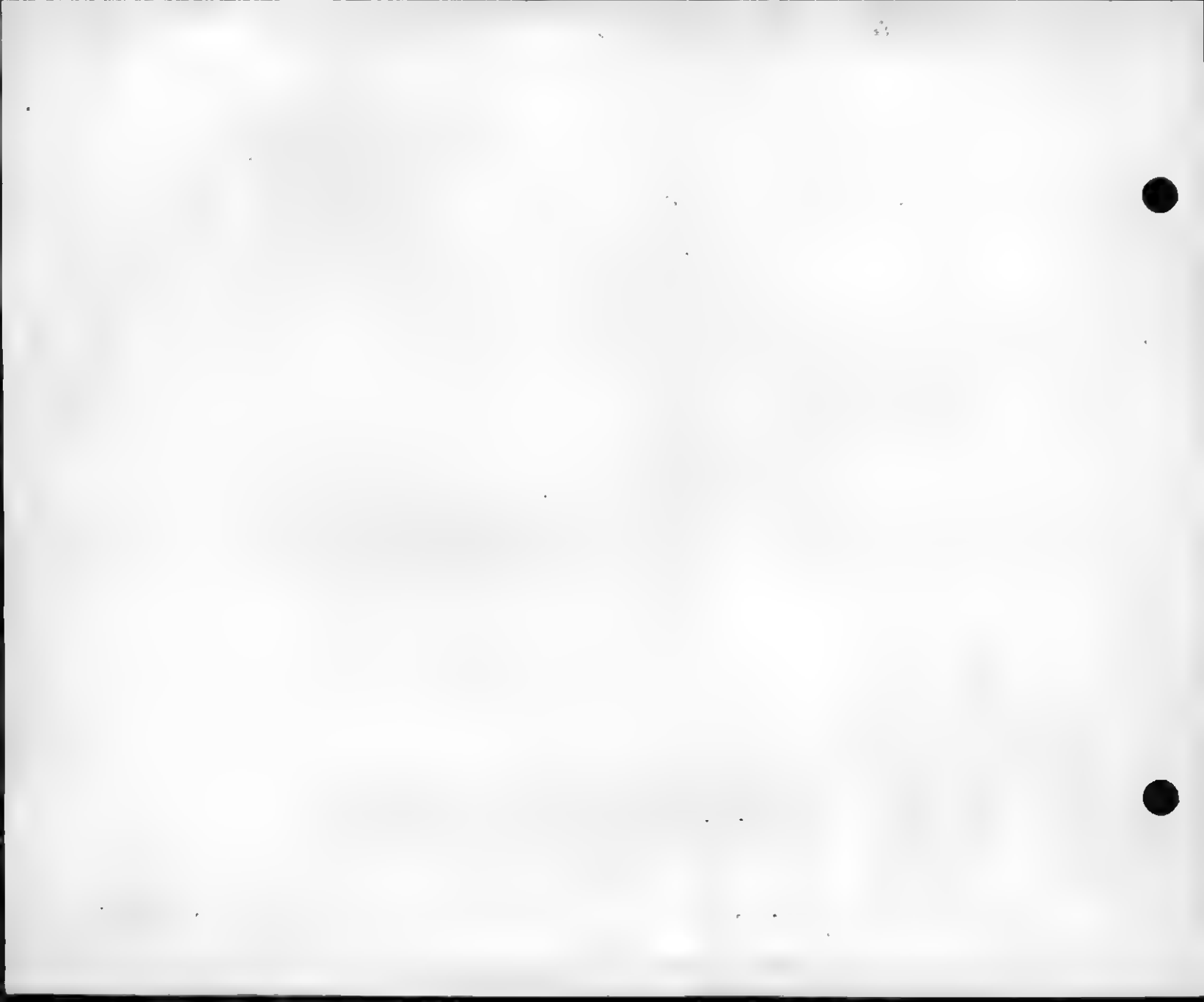


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

| <div>00822</div> <div>Item 21b
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>0-16-60 ans</div> <div>00822</div> | | | | | | | | | | | | | | | | | |
|--|--|-----------------|---------------|---|--|--|--|---|------------------|---|--|---|--|--|--------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or Print) | | | First
CORA | | | Middle
MAY | | | Last
FLUHARTY | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED
<input checked="" type="checkbox"/> JAN. 22 1968 | | | 2b. HOUR
1 P.M. | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
10/6/81 | | 6 AGE (in years
last birthday)
86 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month JAN. 22 Day Year 1968 | | | 2d. HOUR
M | | |
| 7a. BIRTHPLACE (State or foreign
country)
Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
DORCHESTER Md | | | | | |
| 10. CITY OR TOWN OF DEATH
RURAL CAMBRIDGE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
EASTERN SHORE STATE HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
HOUSEWIFE | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE Md. | | | | 13b. COUNTY CAROLINE | | | | 13c. CITY OR TOWN
FEDERALSBURG | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
201 N. MAIN | | | | | |
| 14. FATHER'S NAME
First Middle Last
GEORGE STANT | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
JANE ATKINSON | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service)
216-48-5127T | | | | 17. INFORMANT
ADDRESS
HOSPITAL RECORDS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last
(b) <u>FRACTURE, NECK OF L. FEMUR</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 DAYS
5 MO. | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. ADJUST?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 8/26 67
? P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)
FELL AT HOME | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
HOME | | | | 21f. LOCATION Street or R.F.D. No City or Town County State
FEDERALSBURG, CAROLINE CO., MD. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)
JOHN MACE, M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL CREMATION
REMOVAL (Specify)
Burial | | | | 23b. DATE
Jan. 25, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Hill Crest Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Federalsburg, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
Trampton Funeral Home Federalsburg Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | |

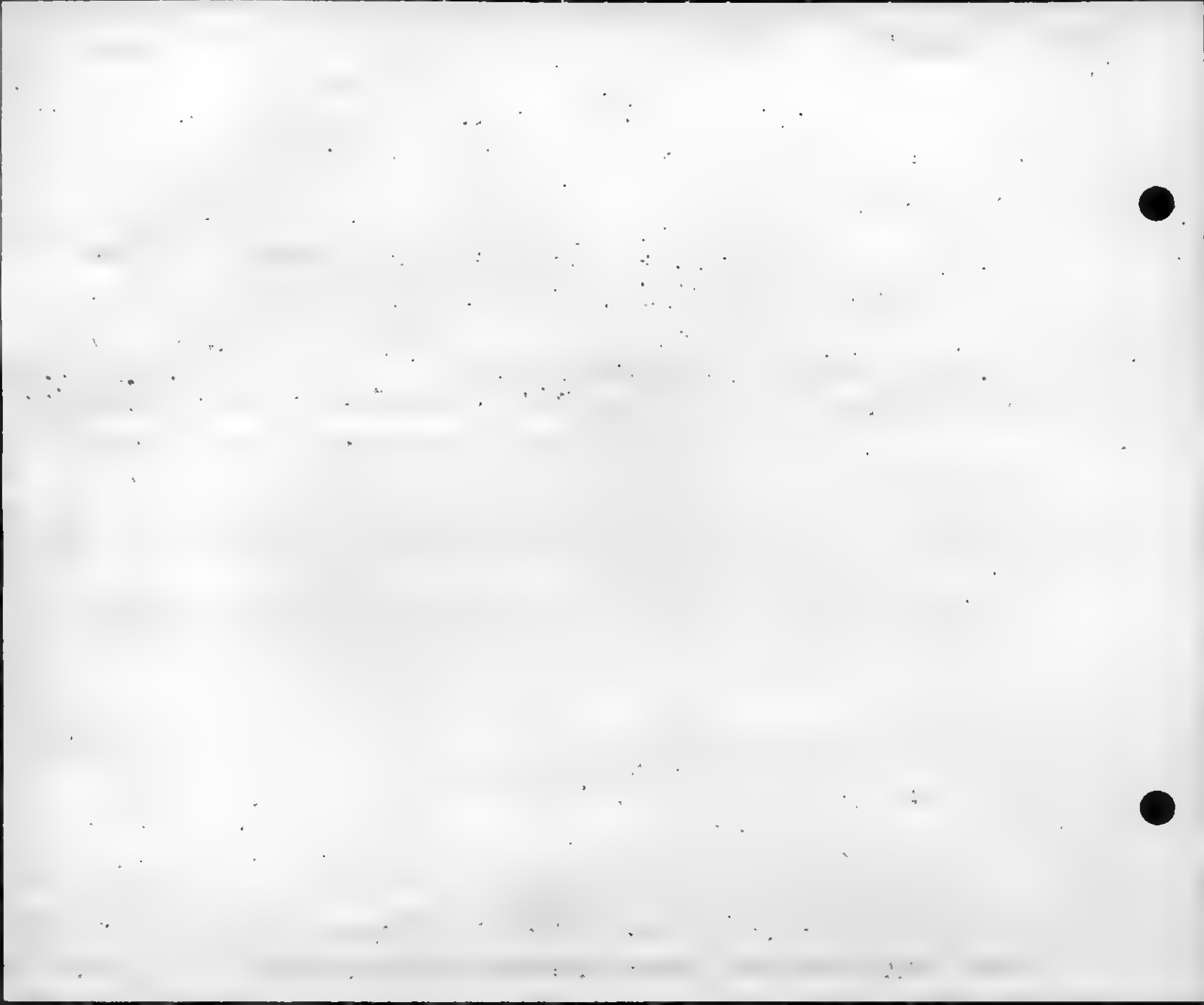


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1/68

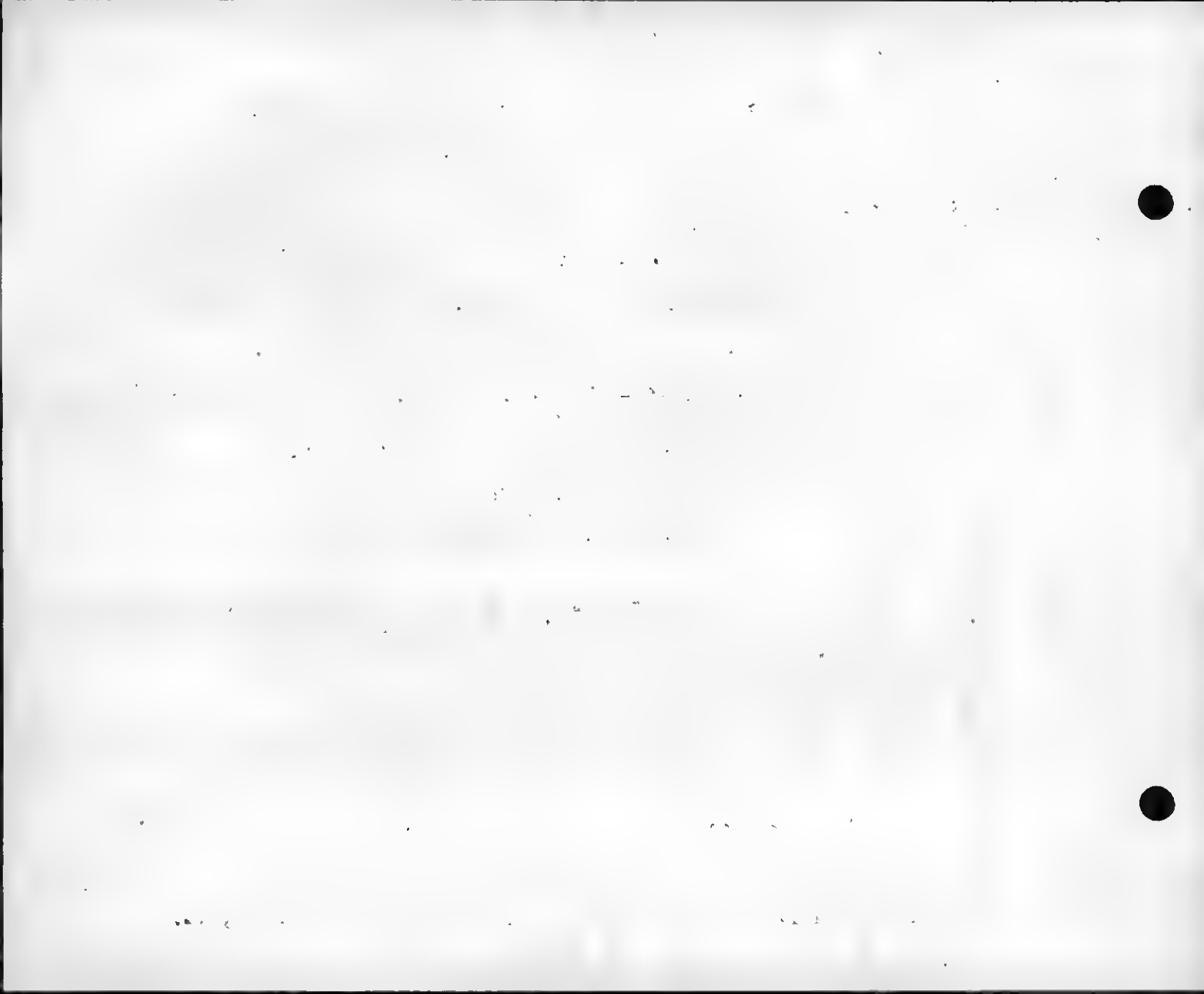
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) Bertha M. Gray | | | 2a. DATE OF DEATH Month Jan Day 12 Year 1968 | | | 2b. HOUR 10A | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 8-30-19 | | 6. AGE (In years lost birthday) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Dorchester Md | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Elliotts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER None | |
| 14. FATHER'S NAME First Snead Middle Elliott Last Elliott | | | 15. MOTHER'S MAIDEN NAME First Maria Middle Buckmaster Last P | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 212-18-6845 | | 17. INFORMANT Records - Eastern Shore State Hosp. | | Address Cambridge | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 1/12 , 19 68 , that (I) (we) last saw the deceased alive on 1/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE E. C. Fernandez | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/12/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) E. C. FERNANDEZ | | | | 22e. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 1/17/1968 | | 23c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM PARK | | 23d. LOCATION (City or Town) (County) (State) CAMBRIDGE, DOR, MD | | | |
| 24. FUNERAL DIRECTOR ANTHONY LeCompte, CAMBRIDGE, MD | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |
| | | | | DATE JAN 16 1968 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|--|--|--|--|--|--------|---|---------|--|--|--|----------|---|--|---------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| 00824 | | | | | 00824 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | |
| Frances | | | Grimes | | Grimes | | 1/29/68 | | Month Day Year | | M | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR
MONTHS DAYS | | | |
| Female | | | White | | | Nov. 29, 1907 | | | 80 | | | YRS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | 10. KIND OF BUSINESS OR INDUSTRY | | | |
| Virginia | | | | | | | | | Dorchester | | | Md. | | | |
| 11. CITY OR TOWN OF DEATH | | | 12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 13a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 14. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Taylor Island | | | Taylor Island | | | Housewife | | | | | | | | | |
| 15a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 15b. COUNTY | | | 15c. CITY OR TOWN | | | 15d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 15e. STREET AND NUMBER | | | |
| Maryland | | | Dorchester | | | Taylor Isl. | | | | | | Taylor Island | | | |
| 16. FATHER'S NAME | | | 17. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| James W. Oliver | | | Lucy N. | | | | | | | | | | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 18b. SOCIAL SECURITY NO. | | | 19. INFORMANT | | | Address | | | | | | |
| No | | | None | | | 215-09-8072 | | | Mr. Harry R. Grimes | | | same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> | | | | | | | | | | 1/26/68 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) <u>Arterio Sclerosis C.V.R.D.</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) <u>Arterio Sclerosis</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 442. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | | | | | |
| | | | HOUR A.M. Month Day Year | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Hot while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION | | | Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>1/29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/29/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/29/68</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | |
| | | | | | | | | | | <u>Cumtuba</u> | | <u>Ma</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | 2/1/68 | | | Western Cemetery | | | Baltimore, Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>Wm. J. Lickert Sons</u> | | | | | | | | | | <u>Baltimore, Md.</u> | | DATE <u>FEB 6 1968</u> | | <u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

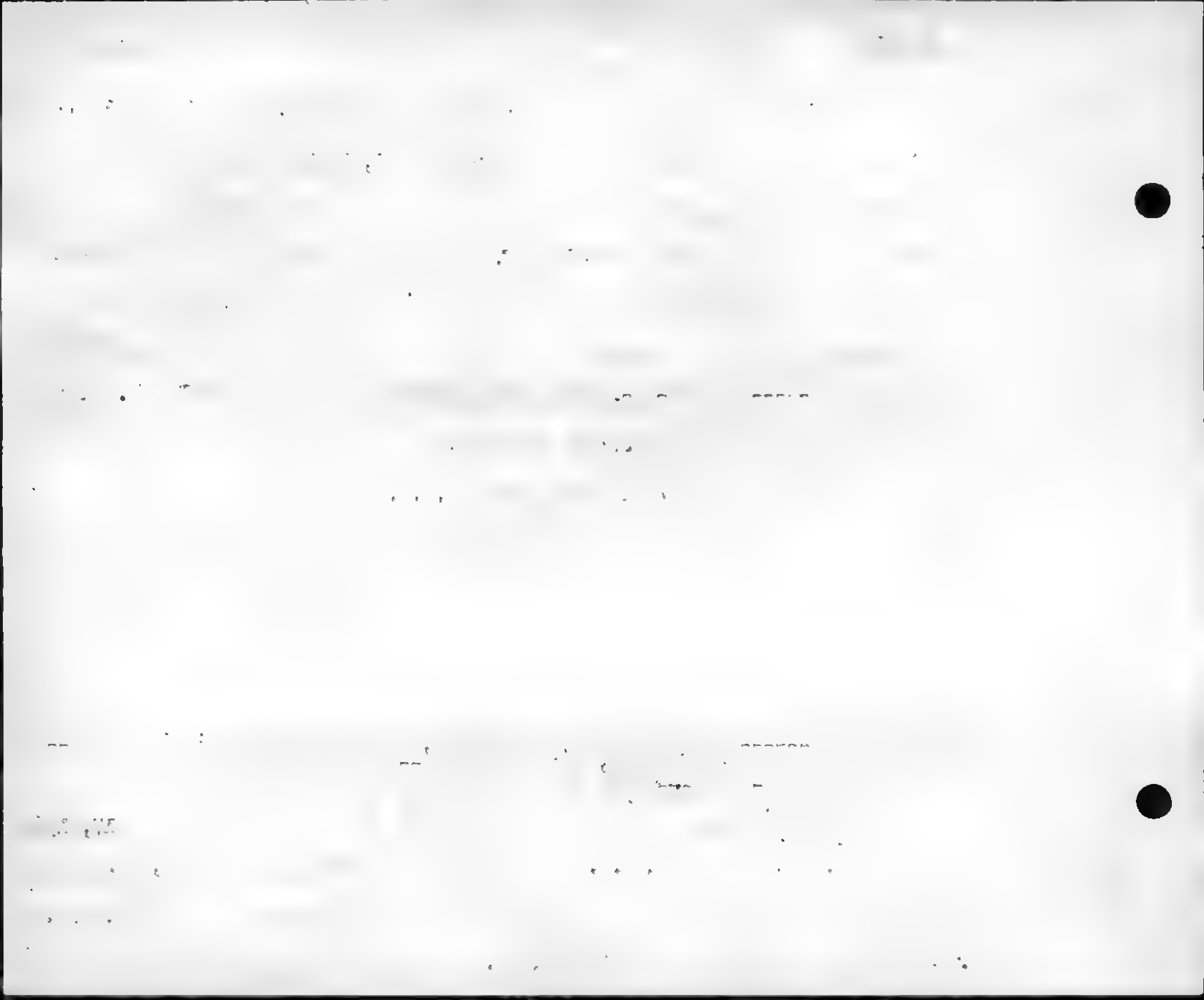
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00825

00825

| | | | | | | | | | | | |
|---|--|--|--|--------|------|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
1:40 PM | | |
| LYDIA | | | WING | | | HAMILTON | | | JANUARY 16 1968 | | |
| 3 SEX
FEMALE | | | 4 RACE
NEGROID | | | 5. DATE OF BIRTH
NOVEMBER 30, 1891 | | | 6. AGE (In years last birthday)
76 YRS. | | |
| 7a BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
DORCHESTER Md. | | |
| 10. CITY OR TOWN OF DEATH
CAMBRIDGE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
835 FAIRMOUNT AVE. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY
LAUNDRESS | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
DORCHESTER | | | 13c. CITY OR TOWN
BECKWITH | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last
CHARLES WING | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ALICE WARFIELD | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO.
141-01-1324A | | |
| 17. INFORMANT
VERNON HAMILTON | | | Address
835 FAIRMOUNT AVE. 21613 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC C.V.D.
DUE TO, OR AS A CONSEQUENCE OF
(c)
410.9 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
420. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 28, 1967, to JANUARY 16, 1968, that (I) (we) last saw the deceased alive on JANUARY 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J. Edwin Fassett, M.D. | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
JANUARY 17, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
J. EDWIN FASSETT, M.D. | | | | | | 22e. ADDRESS
623 HIGH STREET CAMBRIDGE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMAINS (Specify) | | | 23b. DATE
1/21/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BECKWITH | | | 23d. LOCATION (City or Town) (County) (State)
BECKWITH DOR. MD. | | |
| 24. FUNERAL DIRECTOR
Arthur C. Hill | | | | | | ADDRESS
CAMBRIDGE, MD. | | | 25a. REC'D BY REGISTRAR
DATE JAN 30 1968 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John A. Judge | | | | | |



VR A 510
DOMREV 1/68
CT! 26

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Haynes | | | 2a. DATE OF DEATH
Month Day Year
1 15 Day 18 Year | | | 2b. HOUR
7:30 P.M. | | | |
| 3. SEX

Female | | 4 RACE




Colored | | 5 DATE OF BIRTH

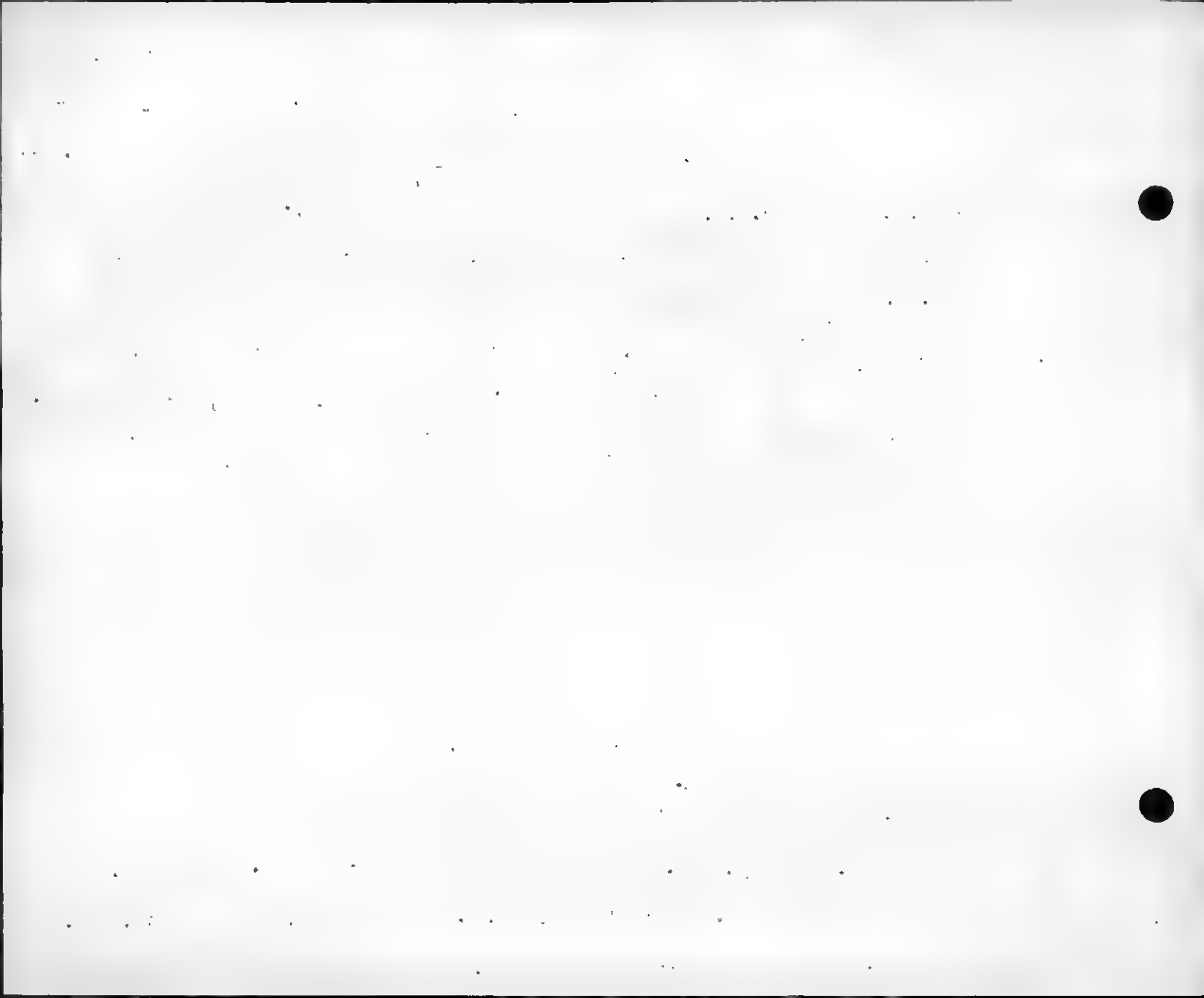
1-13-68 | | 6. AGE (In years last birthday)
YRS.
MONTHS DAYS HOURS MIN | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a BIRTHPLACE (State or foreign country)
Dorchester | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH

Dorchester Md. | | | |
| 10 CITY OR TOWN OF DEATH

Cambridge | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cambridge Maryland Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

None | | 12b. KIND OF BUSINESS OR INDUSTRY

None | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b COUNTY
Dorchester | | 13c CITY OR TOWN
Cambridge | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last
Ernest Edward Haynes Jr. | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Paulette Rose Faye Todd | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Paulette Haynes Rt. 3 Box 54, Cambridge, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-13, 1968 to 1-15, 1968, that (I) (we) last saw the deceased alive on 1-15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE  DEGREE ATTENDING PHYS MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
1-15-68 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Wilbur N. Baumann | | | | | | | | 22e. ADDRESS
10 Aurora Street, Cambridge, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-15-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Lina's Road Cemetary | | 23d. LOCATION (City or Town) (County) (State)
Church Creek Dorch., Md. | | | |
| 24 FUNERAL DIRECTOR ADDRESS Route #3
 | | | | 25a. REC'D BY REGISTRAR
DATE JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 411 (1)
304 REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First
Orlan | | | Middle
Henry, Jr. | | | Last
January | | | 2a. DATE OF DEATH
Month
Day
Year
15 68 | | | 2b. HOUR
10:30 AM | | |
| 3. SEX
male | | | 4. RACE
Colored | | | 5. DATE OF BIRTH
1-15-68 | | | 6. AGE (In years
lost birthday)
YRS | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | IF UNDER 24 WRS.
HOURS
MIN | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Dorchester | | | Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Cambridge Maryland Hospital Inc | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
none | | | 12b. KIND OF BUSINESS OR
INDUSTRY
none | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Dorchester | | | 13c. CITY OR TOWN
Cambridge | | | 13d. INSIDE CITY LIM-TSP
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
300 Byrn Street | | | | | |
| 14. FATHER'S NAME
First
Orlan | | | Middle
Henry | | | Last
Ann | | | 15. MOTHER'S MAIDEN NAME
First
Ann | | | Middle
Peterson | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service)
none | | | 17. INFORMANT
Ann Henry-Rt #1 Box 100 Hurlock, Md. | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u>
1100 DUE TO, OR AS A CONSEQUENCE OF
Aspiration of anesthetic fluid & partial anoxemia
(b) <u>Asphyxiation of lungs</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Phalapse of cord</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-15</u> , 19 <u>68</u> , to <u>1-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. J. Edwin Fassett</u> | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S
NAME (Type)
Dr. J. Edwin Fassett | | | 22e. ADDRESS
623 High St. Cambridge, Md | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
1-20-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Thompsonstown | | | 23d. LOCATION (City or Town) (County) (State)
East New Market Dorch. Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Frampton Funeral Home--Federalburg, Md. | | | 25a. REC'D BY REGISTRAR
DATE
JAN 25 1968 | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | | | |

MEDICAL CERTIFICATION

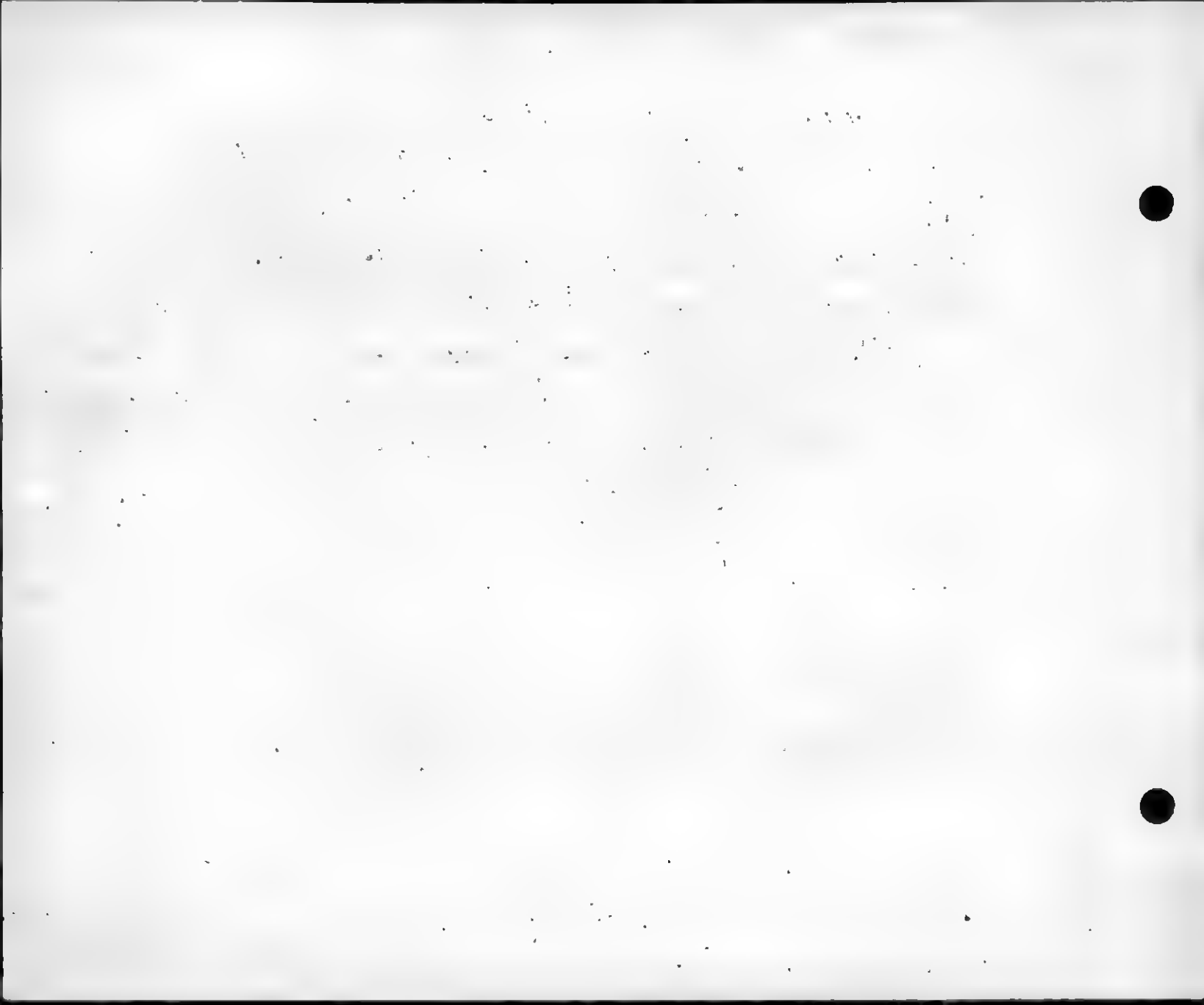


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-5-64
30M REV. 1-60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 00828 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Margaret</i> | | | First <i>H.</i> Middle <i>Hindes</i> Last | | | 2a. DATE OF DEATH Month <i>1</i> Day <i>14</i> Year <i>68</i> | | | 2b. HOUR <i>M</i> | | |
| 3. SEX <i>Female</i> | | | 4. RACE <i>White</i> | | | 5. DATE OF BIRTH <i>05-18-89</i> | | | 6. AGE (in years last birthday) <i>78</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Dorchester</i> Md | | |
| 10. CITY OR TOWN OF DEATH <i>Cambridge</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Eastern Shore State Hosp</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housework</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>xx</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, or residence before admission) STATE <i>Maryland</i> | | | 13b. COUNTY <i>Kent</i> | | | 13c. CITY OR TOWN <i>Rock Hall</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First <i>William</i> Middle <i>J.</i> Last <i>Hindes</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Mary Rebecca</i> Middle <i>Davis</i> Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <i>Eastern Shore State Hosp. Cambridge Md</i> | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>14109 Probable Myocardial Infarction</i> | | | | | | | | | | 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4261</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Atherosclerosis</i> | | | | | | | | | | 2 years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Brain Syndrome</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that the (the hospital) attended the deceased from <i>9-4-</i> , 19 <i>65</i> , to <i>1-14-</i> , 19 <i>68</i> , that (I) the last saw the deceased alive on <i>1-14-68</i> , 19 <i>68</i> , and that in (my) the opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Edward Lewis</i> M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | 22c. DATE SIGNED <i>1-14-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>EDWARD LEWIS, M.D.</i> | | | | | | | | | 22e. ADDRESS <i>ESSH, CAMBRIDGE, MD.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | 23b. DATE <i>JAN. 16</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Rock Hall Maryland</i> | | |
| 24. FUNERAL DIRECTOR <i>Edgar H. Lewis, Church Hill, Md.</i> | | | | | | 25a. REC'D BY REGISTRAR <i>DATE JAN 18 1968</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i> | | |

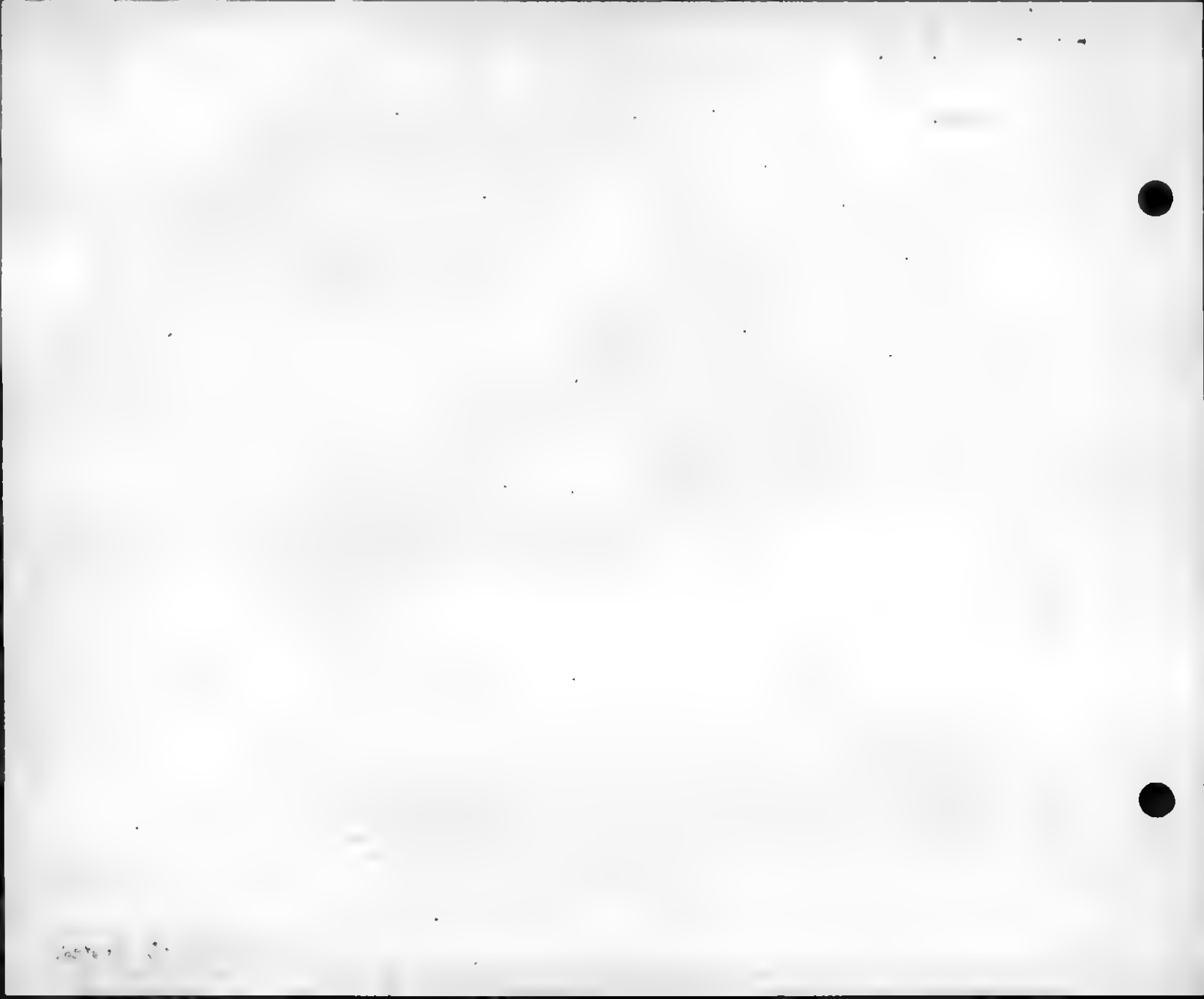


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|-----------------|--|---|--|---|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) Lydia L. Hopkins | | | First Middle Last | | | 2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> JAN 7 1968 | | | 2b HOJR 2:10 P.M. | | |
| 3 SEX F | | 4 RACE W | | 5 DATE OF BIRTH 1-5-83 | | 6 AGE (In years last birthday) 85 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) FINLAND | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Dorchester Md | | |
| 10. C. Y. OR TOWN OF DEATH Cambridge | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) EASTERN SHORE STATE | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Head Cook or chef | | | 12b KIND OF BUSINESS OR INDUSTRY Food | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE Md. | | | 13b COUNTY Wic. | | | 13c CITY OR TOWN MARDELA | | | 3a INSIDE CITY YES NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME William L. LAITINEN | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME MARY KONTTINEN | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b SOCIAL SECURITY NO 063-14-3418 | | | 17. INFORMANT FRANK P. HOPKINS (son) | | | ADDRESS MARDELA, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA
41x7
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause
(b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
10+ YRS | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
1 DAY
10+ YRS | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
42. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH NEITHER | | | | 21b TIME OF INJURY Month, Day, Year 9:30/9/1967 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) FELL ON FLOOR. | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21a PLACE OF INJURY (At home, farm, street, factory, office building, etc.) TAWES BDC. ESSH | | | | 21f LOCATION Street or R.F.D. No CAMBRIDGE City or Town DOR County Md. State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John Mace Jr. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b DATE SIGNED 1/7/68 | | | |
| EXAMINER'S NAME (Type) JOHN MACE JR. | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a BURIAL CREMATION REMOVAL (Specify) Burial | | | | 23b DATE Jan. 9, 1968 | | 23c NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | 23d LOCAT ON (City or town) (County) (State) Salisbury, Wicomico, Maryland | | | |
| 24 FUNERAL DIRECTOR Solloway & Co | | | | ADDRESS Salisbury, Md. | | | | 25a REC'D BY REG STRAR JAN 9 1968 | | 25b REG STRAR'S SIGNATURE Charles Judge | |

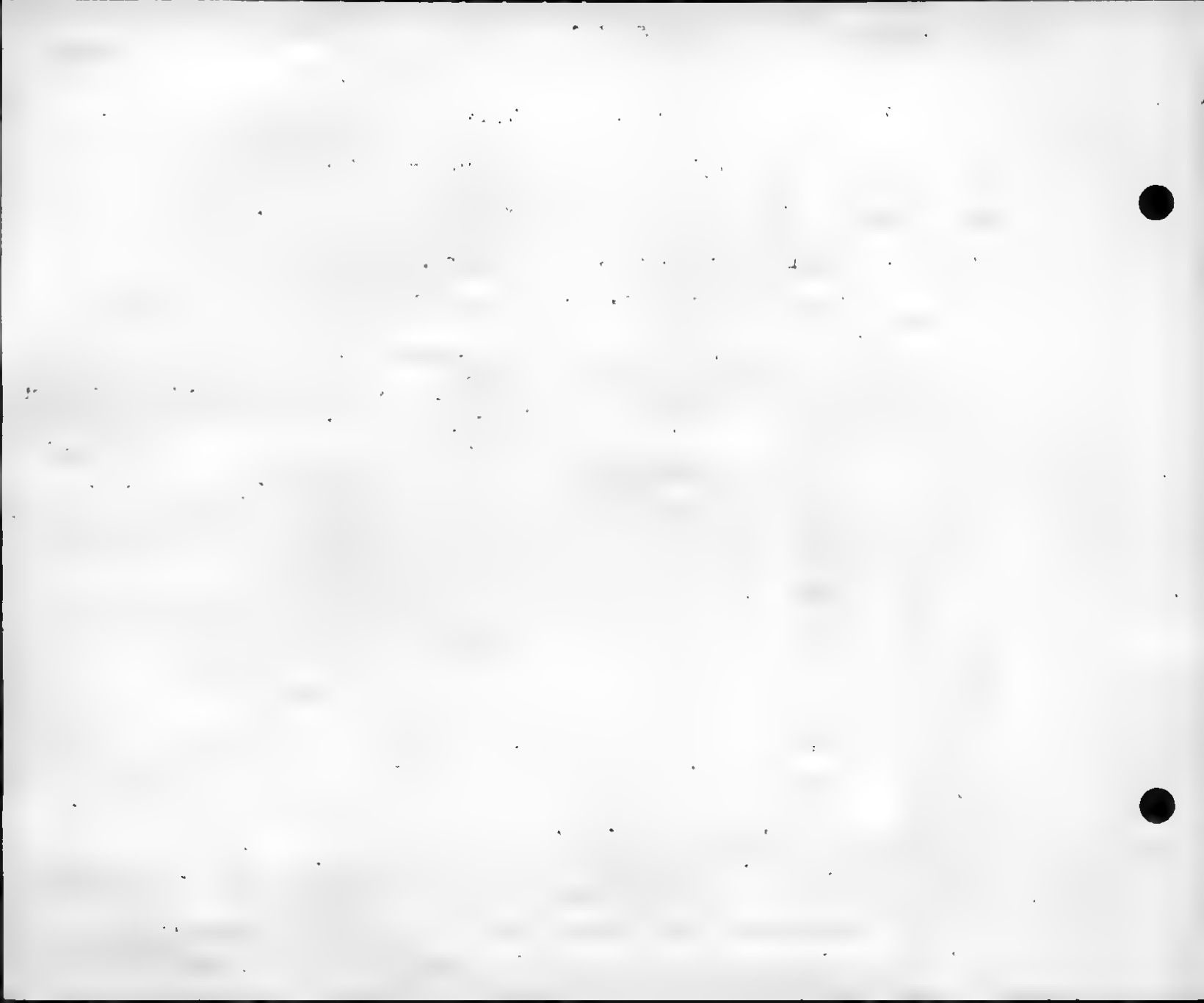


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

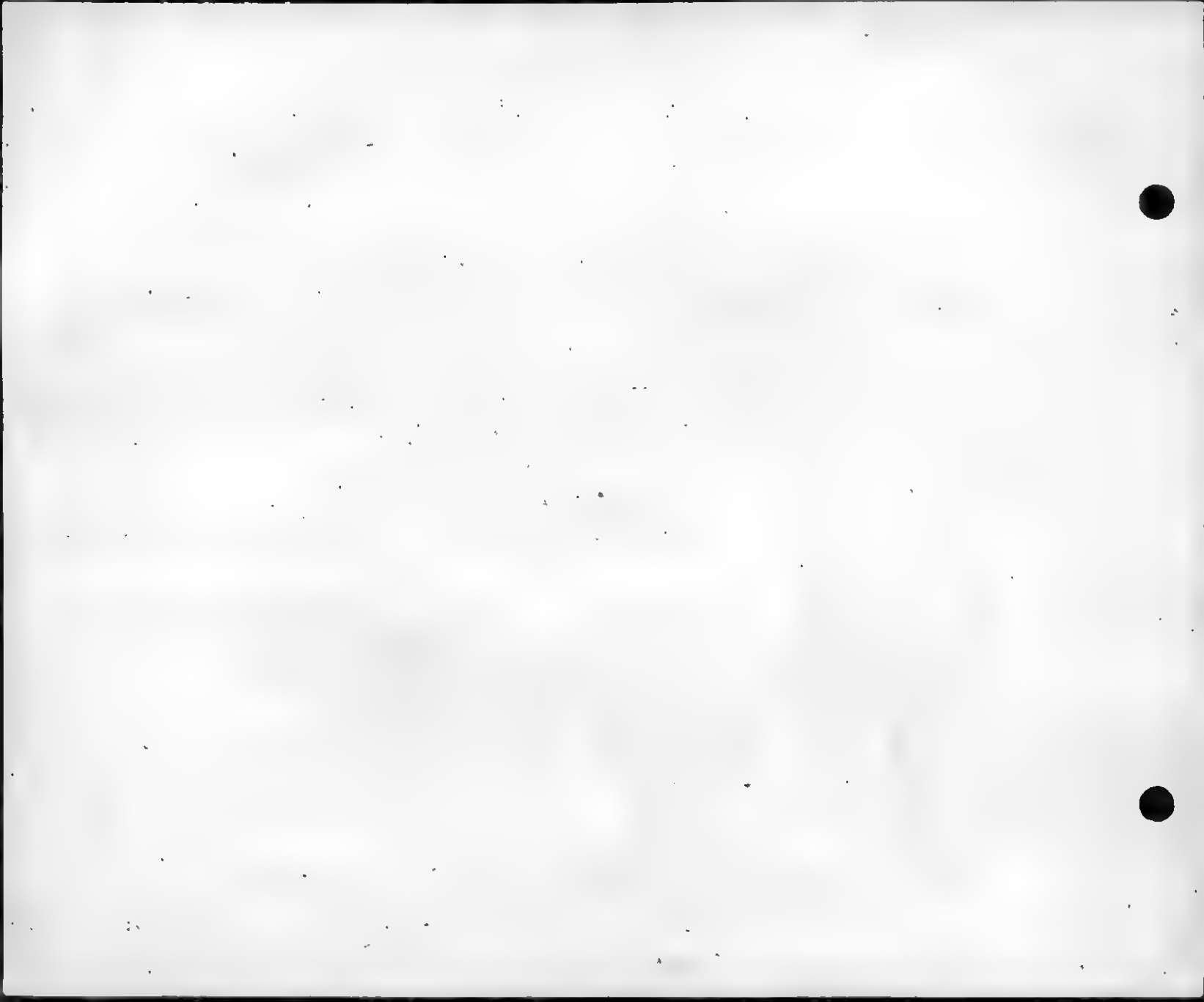
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|--|--|---|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| WALTER EDWARD HORTON | | | | | | Month Day Year
JANUARY 14 68 | | | |
| 1. SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| MALE | | WHITE | | January 19, 1878 | | 89 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Connecticut | | USA | | | | DORCHESTER Md. | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| CAMBRIDGE (RURAL) | | EASTERN SHORE STATE HOSP. | | GARDENER | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | WICOMICO | | SALISBURY | | | | 201 HAYWARD AVENUE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
Daniel B. Horton | | | First Middle Last
UNKNOWN Henrietta Lenk | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | | | | |
| UNKNOWN No | | 557-36-1748 | | Mr. Craig W. Horton (Son) Address
RECORDS OF THE EASTERN SHORE STATE HOSPITAL
R.D.#7, Calvin Dr., Salisbury, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Right Pneumonia</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> | | | | | | <u>4 years</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>4500</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Uremia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2-23-1966</u> to <u>1-14-1968</u> , that (I) (we) last saw the deceased alive on <u>1-14-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Edward Lewis</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>1-14-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS MD</u> | | | | | | 22e. ADDRESS <u>ESSH, CAMBRIDGE, MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Jan. 17, 1968 | | Wicomico Memorial Park | | Salisbury, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | | DATE JAN 19 1968 | | <u>[Signature]</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|---|--|---------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 00832 | | | | | | | | | | | | |
| 00831 | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last
Rachel Elizabeth Hundley | | | | | | 2a DATE OF DEATH Month Day Year
1 24 1968 | | | 2b HOUR
8 4 M | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
00-00-84 | | | 6 AGE (In years last birthday)
84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
USA. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md | | | | | | |
| 10 CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Eastern Shore State Hospital | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | | 13b COUNTY
Wicomico | | 13c CITY OR TOWN
Salisbury | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
609 Oak Hill Ave | | | |
| 14 FATHER'S NAME First Middle Last
Bill Johnson | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Susan Spence | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
— | | 17 INFORMANT Address
Eastern Shore State Hospital Records | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF <u>days</u> | | | | | | | | | | | | |
| (c) <u>senility</u> DUE TO, OR AS A CONSEQUENCE OF <u>years</u> | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4.1.1</u> | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>11-03</u> , 19 <u>62</u> , to <u>1-24</u> , 19 <u>68</u> , that (H) (we) last saw the deceased alive on <u>1-24</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Rene E. Smith</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>1-24-68</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Rene E. Smith</u> | | | | | | 22e. ADDRESS <u>Eastern Shore State Hospital</u> | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE <u>1/26/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CAPE CHARLES</u> | | 23d. LOCATION (City or Town) (County) (State) <u>CAPE CHARLES N.H. VA</u> | | | | | | |
| 24 FUNERAL DIRECTOR <u>LeCamp F. J. 308 High St Camb-Md</u> | | | | | | 25a. REC'D BY REGISTRAR <u>1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>JAN 26 1968</u> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

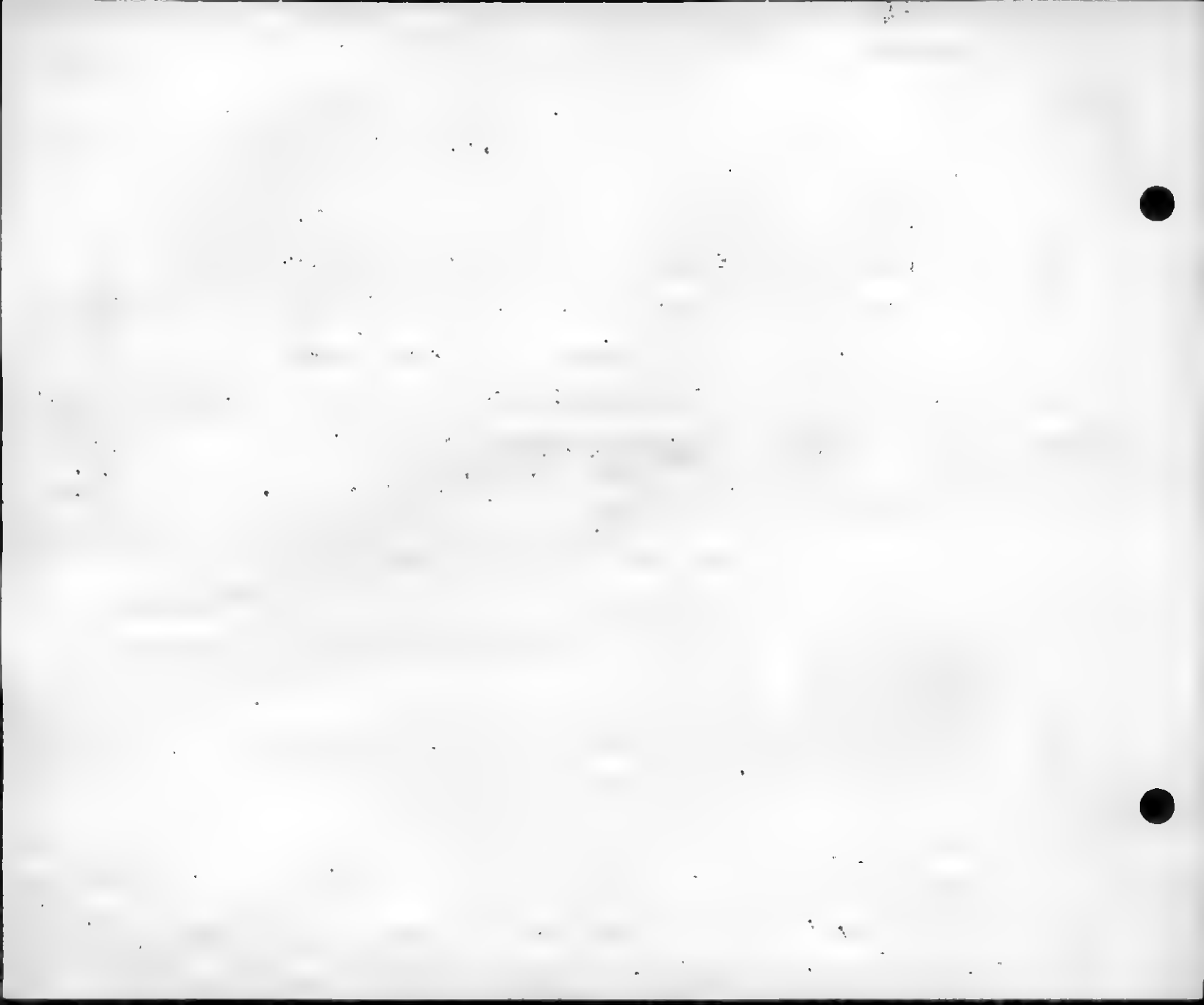
CERTIFICATE OF DEATH

30833

00832

| | | | | | | | | | |
|--|------------------------------|---|---|--|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M | | |
| GARFIELD | | JACKSON | | | JANUARY 14 1968 | | | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| MALE | NEGRO | | Sept. 7 1907 | | 60 YRS | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| MARYLAND | USA | | | | DORCHESTER | | Md | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | | | |
| CAMBRIDGE | | EASTERN SHORE STATE HOSP | | | LABORER | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | SOMERSET | | CRISFIELD | | | | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| John Jackson | | | Ann Corbin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
UNKNOWN | | 16b. SOCIAL SECURITY NO
(If yes give war and dates of service) | | 17. INFORMANT
Address | | | | | |
| No | | SS-215-07-2434 | | RECORDS OF THE EASTERN SHORE STATE HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Generalized Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 day
29 mos | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from 8-9-65, to 1-14-1968, that (I) (we) last
saw the deceased alive on 1-14-1968 and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | EDWARD LEWIS, M.D. | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1-14-68 | |
| 22d. PHYSICIAN'S
NAME (Type) | | EDWARD LEWIS, M.D. | | 22e. ADDRESS | | ESSH, Cambridge, Md | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 1/18/68 | | Ashbury | | Crisfield Md. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. DIED BY REGISTRATION
DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Anthony E. Ward | | Crisfield, Md. | | JAN 18 1968 | | Johnas Judge | | | |

MEDICAL CERTIFICATION



00834 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
Item 1d Film G397 1/24/68 kkc **CERTIFICATE OF DEATH**

008333

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE MARYLAND b. COUNTY QUEEN ANNE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CAMBRIDGE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
STEVENSVILLE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
CAMBRIDGE Hospital | | d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Edna Virginia Jean | | 4. DATE OF DEATH
Month JAN. Day 10 Year 1968 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 6 - 1895 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR
Months 72 Days 72 Hours 72 Min. 72 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
xx | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
HARRY JOHNSON | | 14. MOTHER'S MAIDEN NAME
LUELLA HEDRICK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
xx | | 16. SOCIAL SECURITY NO.
xx | |
| 17. INFORMANT
GRAYSON JEAN - STEVENSVILLE MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Diabetes mellitus
DUE TO
(c) Indefinite
INTERVAL BETWEEN ONSET AND DEATH
14 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 160X NONE
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-8 1967 to 1-10 1967 that (I) (we) last saw the deceased alive on 1-9 1967 and that death occurred at 8:45 M, from the causes and on the date stated above | | | |
| 22a. SIGNATURE
Richard G. Bilzocan | | 22b. DATE SIGNED
1-11-68 | |
| 22c. PHYSICIAN'S NAME (Type)
RICHARD G. BILZOCAN | | 22d. ADDRESS
CAMBRIDGE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
JAN. 12 | |
| 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION (City, town, or county) (State)
BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Edgar L. Lane - Church Hill Md. | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | |
| 25b. REGISTRAR'S SIGNATURE
William L. Judge | | | |

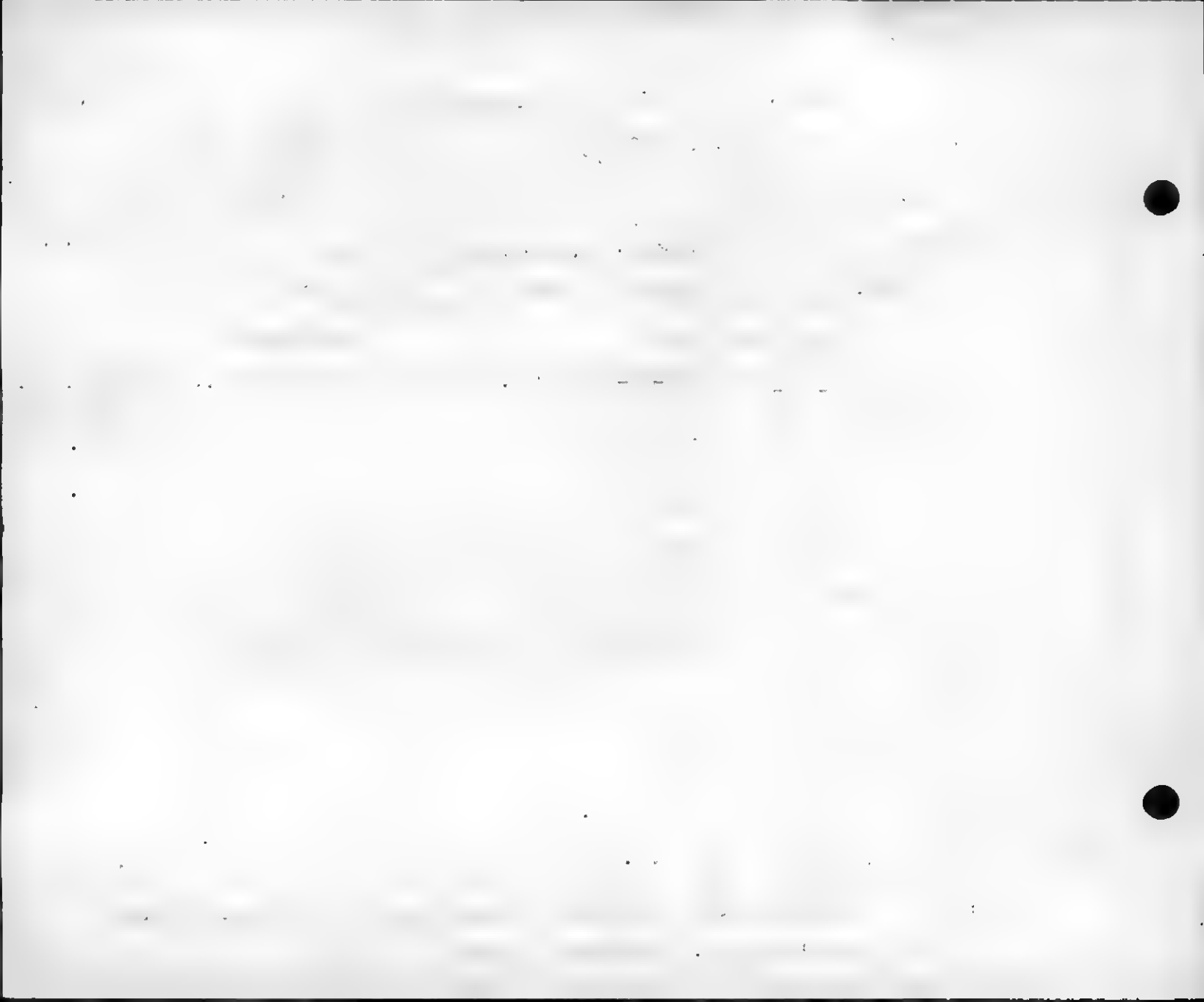


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | |
|---|--|------------------------|------------------------|--|--|---|--|--|-----------------------------|--|--|--|--|--------------------------------------|-------------------------------|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First
GEORGE | | | Middle
OTTO | | | Last
KRAEGERBRINK | | | 2a DATE KNOWN OF DEATH
Month Day Year
Jan 28 1968 | | | 2b HOUR
M
6 A.M. | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
July 12, 1893 | | 6 AGE (in years)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD
Month Day Year
Jan 28 1968 | | | 2d HOUR
M
6 A.M. | | | | |
| 7a BIRTHPLACE (State or foreign country)
Wisconsin | | | | 7b CITIZEN OF WHAT COUNTRY?
USA | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 COUNTY OF DEATH
Dorchester | | | | Md | | | |
| 10 CITY OR TOWN OF DEATH
Cambridge | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cambridge Md. Hospital | | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)
Farmer | | | | 12b KIND OF BUSINESS OR INDUSTRY
Dirt | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE
Md. | | | | 13b COUNTY
Dorchester | | | | 13c CITY OR TOWN
Cambridge | | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e STREET AND NUMBER
509 Gay Street | | | |
| 14. FATHER'S NAME
First Middle Last
Carl Kraegerbrink | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Annie Kraeger | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
218-20-3668 | | | | 17 INFORMANT
Mrs. James Moore | | | | ADDRESS
509 Gay St., Cambridge, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unkn.
Unkn. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
221X | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John Wace Jr. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | 22b DATE SIGNED
1/28/68 | | | | | | | |
| EXAMINER'S NAME (Type)
John Wace Jr. M.D. | | | | | | ADDRESS (Street, city, town, or county)
Cambridge, Md. | | | | | | | | | | | | | |
| 23a BURIAL OR CREMATION, REMOVAL (Specify)
Burial | | | | 23b DATE
Jan 31 1968 | | | | 23c NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park | | | | 23d LOCATION (City or Town) (County) (State)
Cambridge, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | | | | | ADDRESS
 | | | | 25a REC'D BY REGISTRAR
JAN 30 1968 | | | | 25b REGISTRAR'S SIGNATURE
 | | | | | |

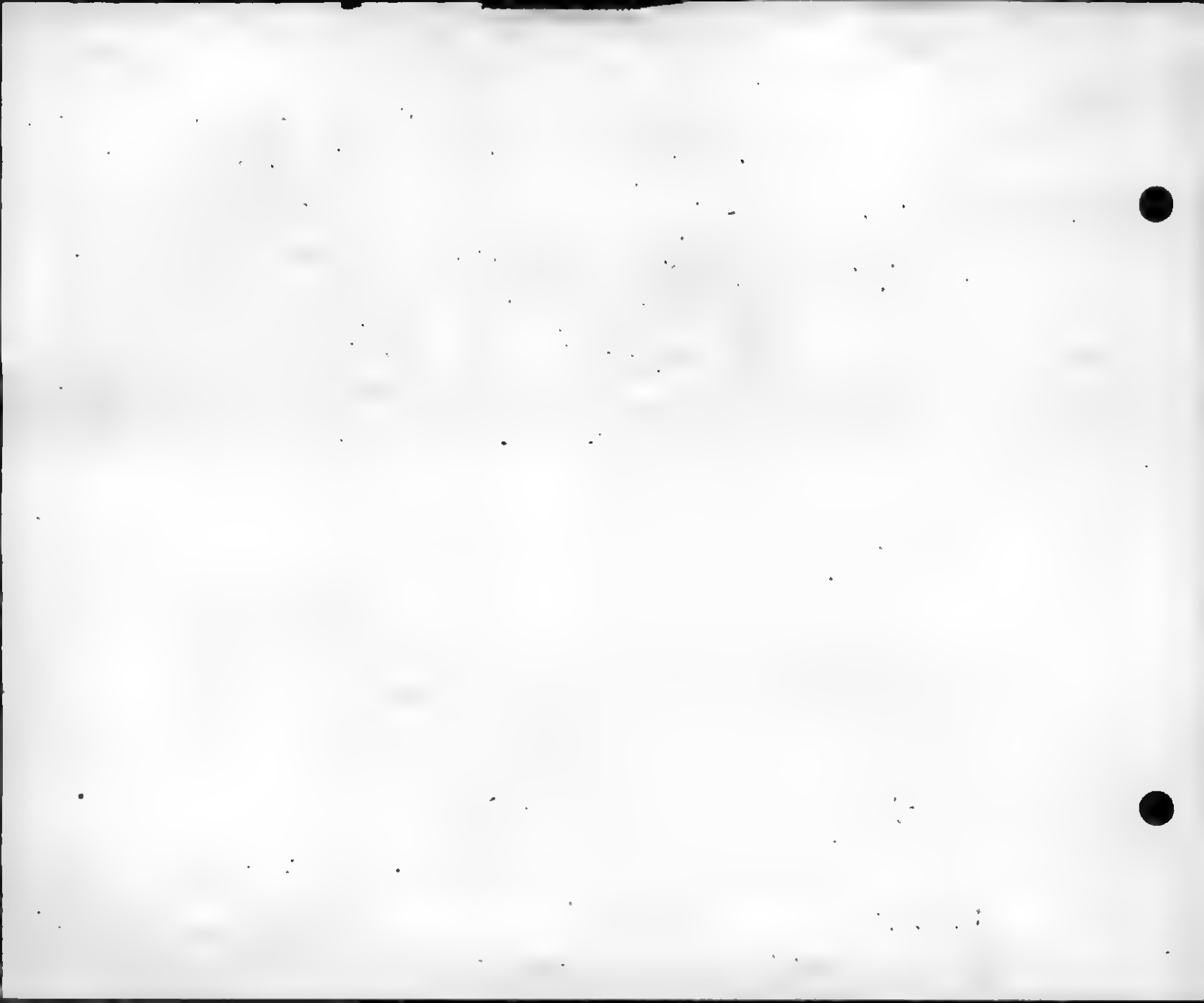


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-1-68
30M REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|---|---|------------------------------------|--|---|---|------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 00835 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>William John Langfitt Sr.</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month <i>1</i> Day <i>8</i> Year <i>68</i> | | 2b. HOUR
<i>11:30 PM</i> | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>9/4/1884</i> | | 6. AGE (In years
last birthday) <i>83</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Dorchester</i> Md | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Cambridge</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <i>Cambridge Maryland</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) <i>Farmer</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY <i>Farm</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Dor.</i> | | 13c. CITY OR TOWN
<i>Vienna</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME
<i>George M. Langfitt</i> | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
<i>Anna Delahoe</i> | | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <i>No</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
<i>William J. Langfitt Jr.</i> | | | Address
<i>Vienna, Md</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>CEREBRAL ACCIDENT</i>
<i>4369</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>28 DAYS</i> | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/11, 1967</i> to <i>1/8, 1968</i> , that (I) (we) last
saw the deceased alive on <i>1/8, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>W.E. GURBY JR.</i> | | 22c. DATE SIGNED
<i>1/9/68</i> | | 22d. PHYSICIAN'S
NAME (Type) <i>W.E. GURBY JR.</i> | | 22e. ADDRESS
<i>CAMBRIDGE MD.</i> | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF
PHYS <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<i>1/11/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Vienna</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Vienna Dor Md</i> | | 23e. REC'D BY REGISTRAR
DATE <i>JAN 12 1968</i> | | |
| 23f. FUNERAL DIRECTOR
<i>Rich S. Thillonghy, East New Market, Md.</i> | | 23g. ADDRESS | | 23h. REGISTRAR'S SIGNATURE
<i>Charles Jones</i> | | 23i. REGISTRAR'S SIGNATURE | | 23j. REGISTRAR'S SIGNATURE | | |



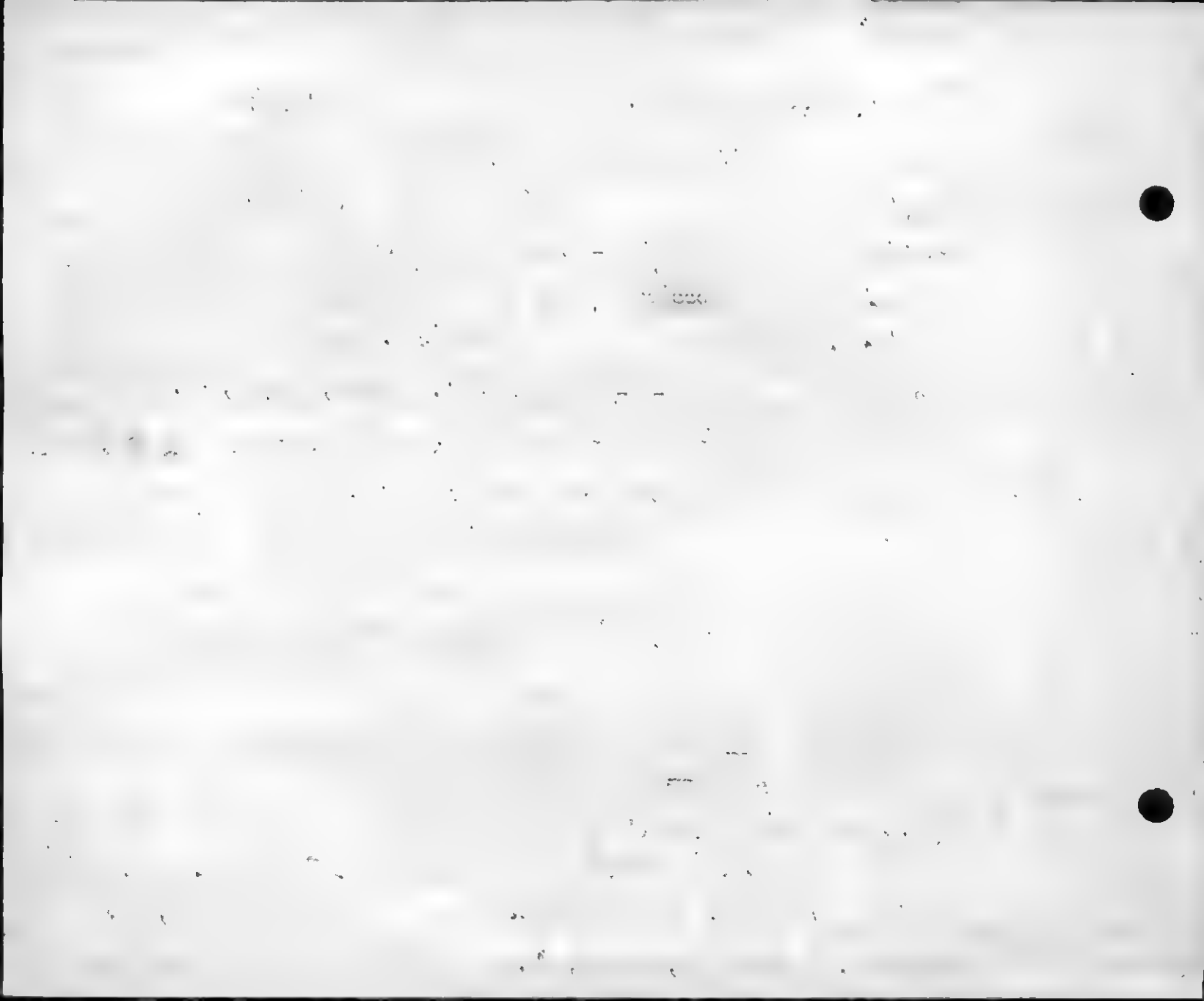
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VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--------------------------------------|------------------------|------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Florence Noama LaPauze | | | | | | 2a. DATE OF DEATH
1/26/1968 Day Year | | | 2b. HOUR
M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
7/5/1899 | | | 6. AGE (in years
lost birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Cambridge-Maryland | | | 12a. USUAL OCCUPATION (Kind of work done
during most of adult life, even if retired)
Housework | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) Maryland | | | 13b. COUNTY Trappe | | | 13c. CITY OR TOWN
Trappe | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last
Charles N. Spence | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Martha F. Bryan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
212-34-3405 | | | 17. INFORMANT Address
Armand L. LaPauze, Trappe, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Recurrent adenocarcinoma of 6 1/2 years
DUE TO, OR AS A CONSEQUENCE OF
(b) Sigmoid colon with
DUE TO, OR AS A CONSEQUENCE OF
(c) metastases
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1533 | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/27/64 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Adenocarcinoma of sigmoid | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 11, 1962 to Jan 26, 1968 , that (I) (we) lost
saw the deceased alive on Jan 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lewis M. Burdette DEGREE ATTENDING
PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
Jan 26 68 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) Lewis M. Burdette | | | | | | 22e. ADDRESS
4 Aurora St. Cambridge, Md | | | | | |
| 23a. BURIAL, CREMATION,
REMOVING BODY | | 23b. DATE
1/29/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
East New Market | | | 23d. LOCATION (City or Town) (County) (State)
East New Market, Md. | | | | |
| 24. FUNERAL DIRECTOR
MAURICE E. NEUNAM & SON, Easton, Md. ADDRESS | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 2 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

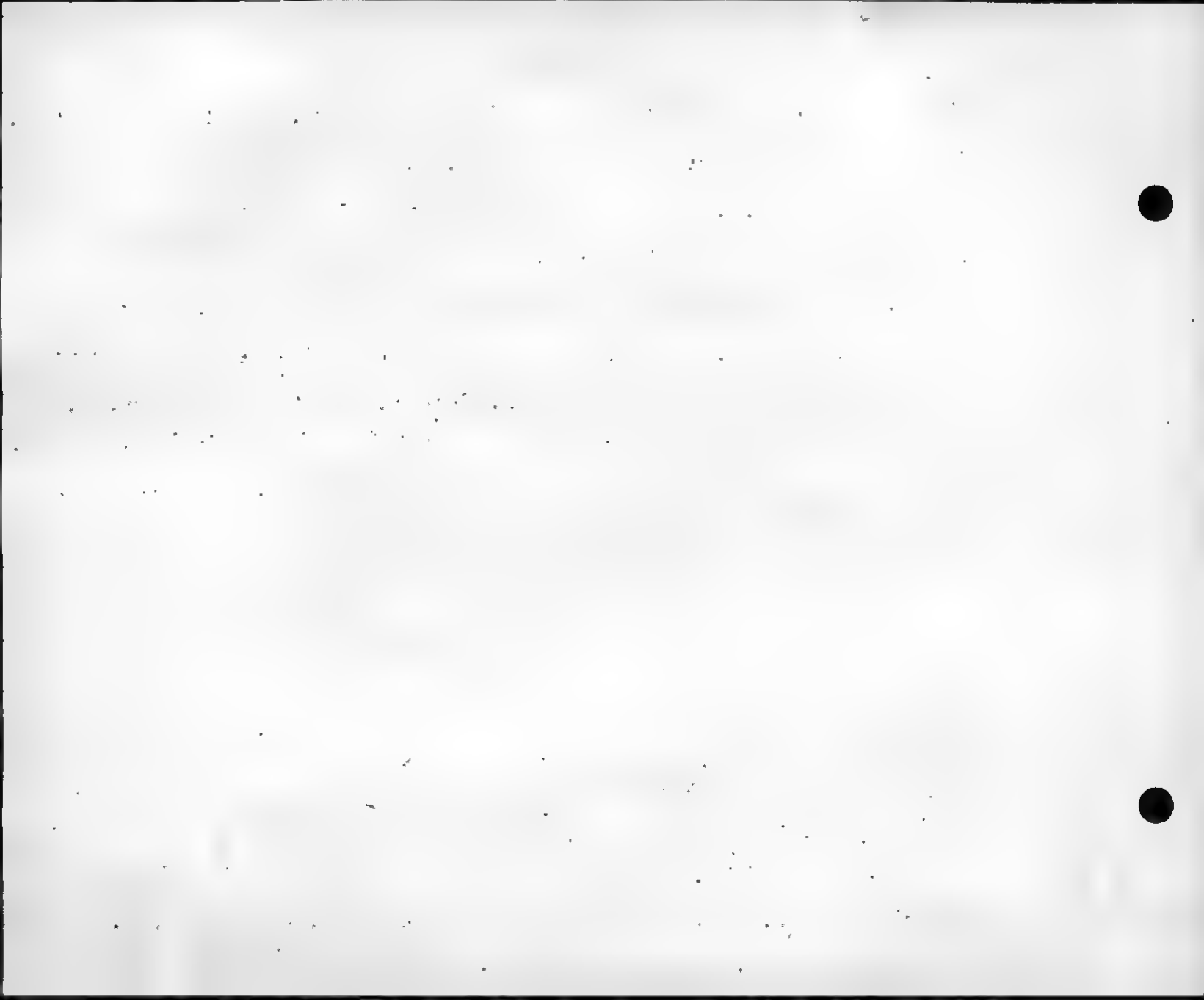


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VR A15 (4)
304A REV 1/68

| 00837 | | | | | | | | | | | |
|---|--|-----------------------------|---|--|--|--|--|---|--|-----------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Agnes Ryan Link | | | | | | Jan. 31 1968 | | | 10 A.M. | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | | White | | Dec. 30, 1896 | | | | 71 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Baltimore | | U.S. | | | | Dorchester Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Cambridge | | | 410 Edlon Park | | | Homemaker | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Dorchester | | Cambridge | | x | | 410 Edlon Park | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Thomas C. Ryan | | | Mary Ellen Consodine | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | | | | | |
| No | | | | | Mrs. Edwin B. Phillips, Cambridge Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 5 YEARS | | | | | | | | | | | |
| 402X DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION 20 YEARS | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-19-1951 to 1-30-1968, that (I) (we) last saw the deceased alive on 1-30-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | |
| W.E. GURBY JR. M.D. DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | |
| 22c. DATE SIGNED 2/1/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) W.E. GURBY JR. 22e. ADDRESS 19 FRANKLIN ST. CAMBRIDGE | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | Feb. 3, 1968 | | Dorchester Memorial Park, Cambridge, Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. RECEIVED BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Kenneth R. Howear | | | Cambridge, Md. | | | FEB 5 1968 | | | | | |



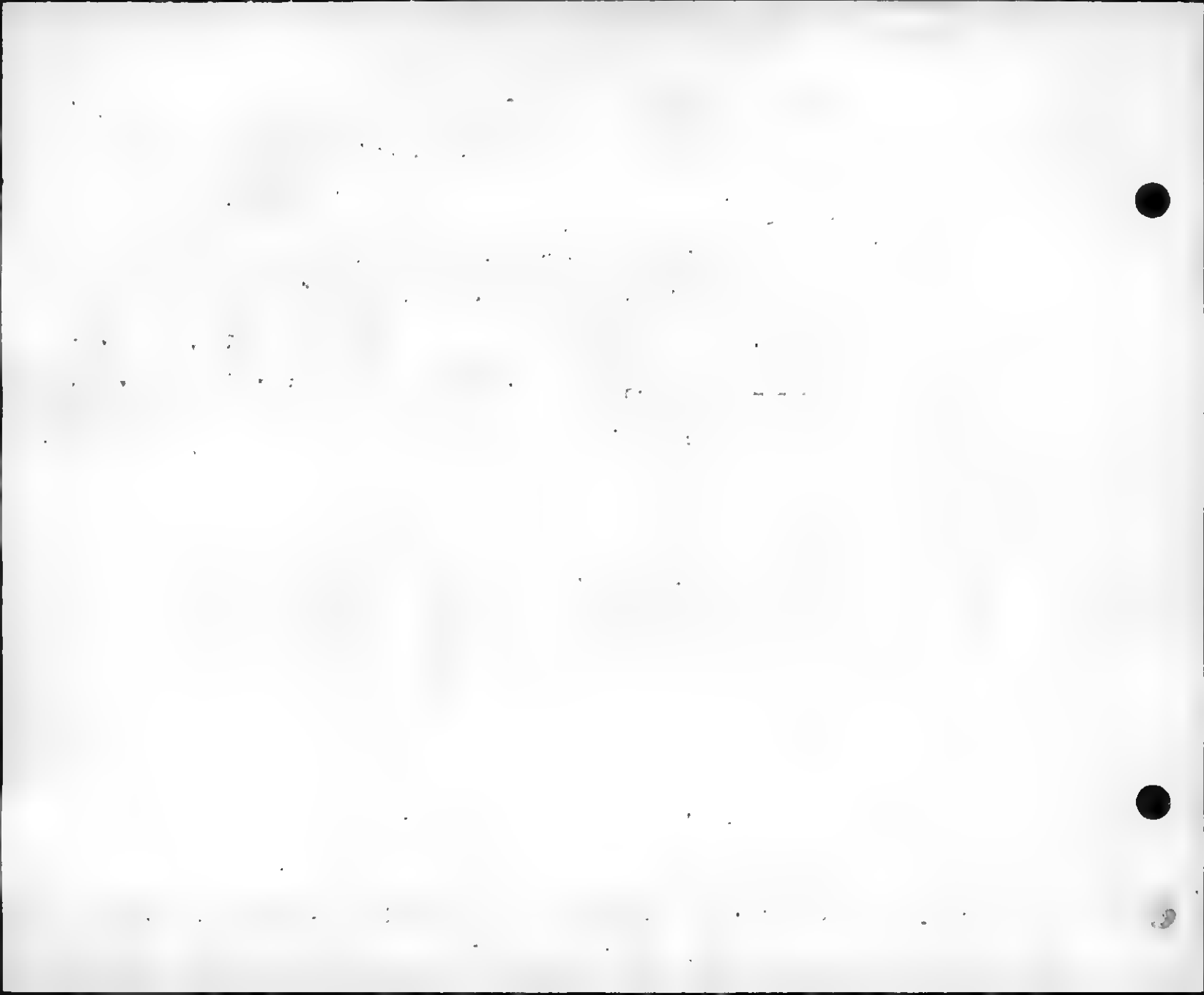
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VR 11-1
30M REV 1-68

| <div style="display: flex; justify-content: space-between;"> 00833 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00838 </div> | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First NAOMI Middle LEWIS Last LLOYD | | | | | | 2a. DATE OF DEATH
Month Jan Day 10 Year 1968 | | | 2b. HOUR
4:48 AM | | |
| 3 SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Dec. 17, 1897 | | 6. AGE (in years last birthday)
70 YRS | | 7. UNDER YEAR
MONTHS 10 DAYS 10 | | IF UNDER 24 HRS.
HOURS 4 MIN 48 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cambridge Md. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md | | | 13b. COUNTY
Dorchester | | 13c. CITY OR TOWN
Cambridge | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
807 Peachblossom Avenue | | |
| 14. FATHER'S NAME First Daniel Middle J. Last Lewis | | | | 15. MOTHER'S MAIDEN NAME First Cera Middle M E. Last Moore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) --- | | | | 16b. SOCIAL SECURITY NO.
No | | 17. INFORMANT Address Mr. Robert K. Lloyd, Cambridge, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Coma</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver Cancer</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5-10</u> (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Esophageal Varices</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>67</u> , to <u>1-10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Richard S. Bilodeau</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1-11-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) RICHARD BILODEAU | | | | | | 22e. ADDRESS
CAMBRIDGE, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan 12 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park | | 23d. LOCATION (City or Town)
Cambridge, Maryland | | (County) _____ (State) _____ | | | |
| 24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

MEDICAL CERTIFICATE ON



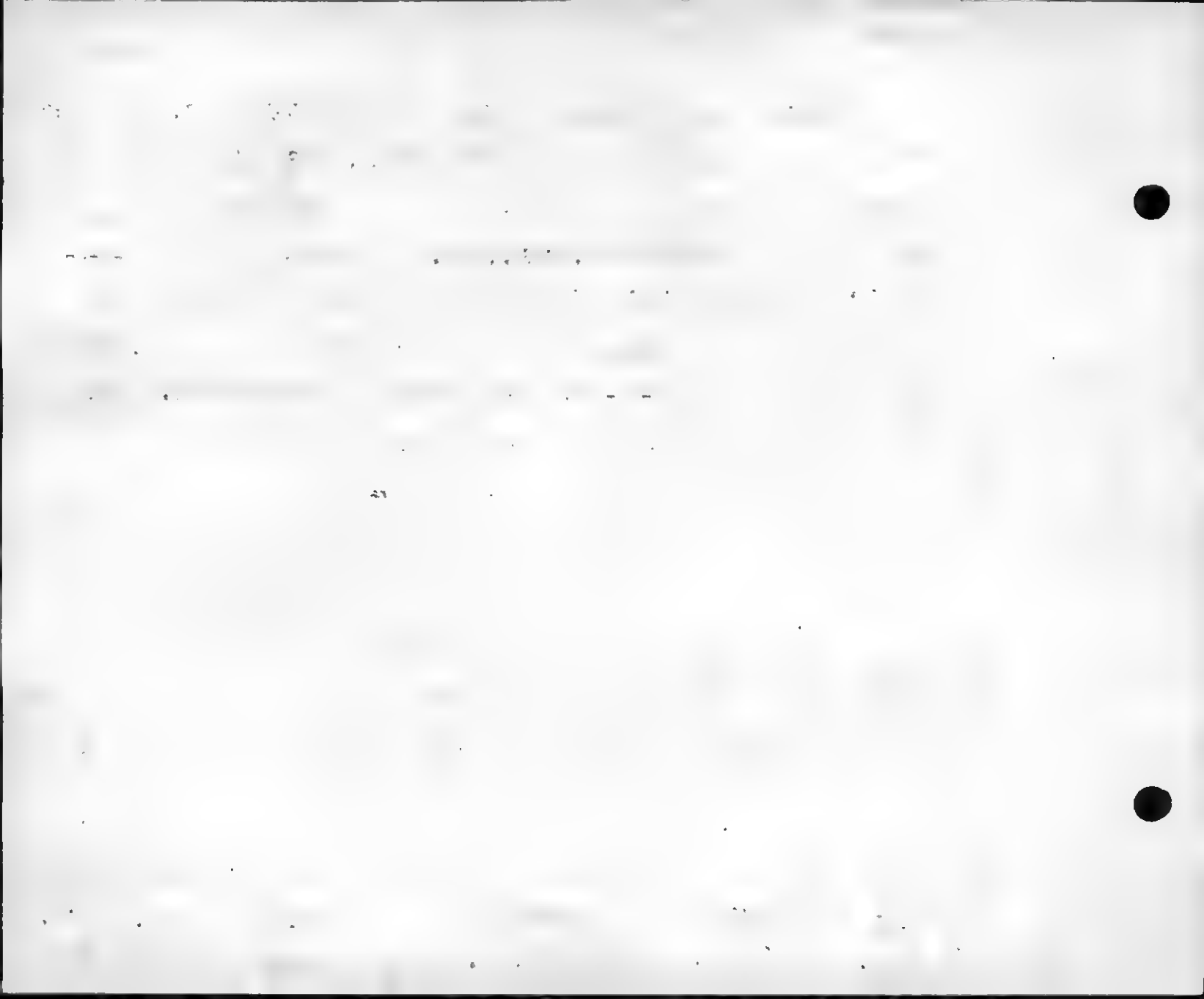
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-1-68
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| VIRGINIA LEE HUGHES LYTE | | | | | | JANUARY 1, 1968 | | 8:30 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | FUNDER 1 YEAR IF UNDER 24 HRS | |
| MALE | | NEGROID | | FEBRUARY 21, 1922 | | 44 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | DORCHESTER | | Md | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CAMBRIDGE | | CAMBRIDGE MD. HOSP., INC. | | LABORER | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | DORCHESTER | | CAMBRIDGE | | | | 1004 JIMSON ROAD | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| ROBERT HUGHES | | | ELEANOR Lecompte | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (if yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | 220-01-2922 | | ELSIE HUGHES | | 1004 JIMSON RD. 21613 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>SQUAMOUS CELL CARCINOMA OF RECTUM</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 1-6-67 | | CARCINOMA OF RECTUM | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (U) (this hospital) attended the deceased from 1-4, 1962, to 1-1, 1968, that (U) (we) last saw the deceased alive on 12-31, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (U) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James F. McCarter, M.D. | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-8-68 | |
| 22d. PHYSICIAN'S NAME (Type)
JAMES F. MCCARTER, M.D. | | | | 22e. ADDRESS
Box 386
CAMBRIDGE, MARYLAND, 21613 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 1/7/68 | | MADISON | | MADISON DOR. MD. | | | |
| 24. FUNERAL DIRECTOR
L. C. Davis | | | | ADDRESS
CAMBRIDGE, MD. | | 25a. REC'D BY REGISTRAR
DATE JAN 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION ON



MARYLAND STATE DEPARTMENT OF HEALTH

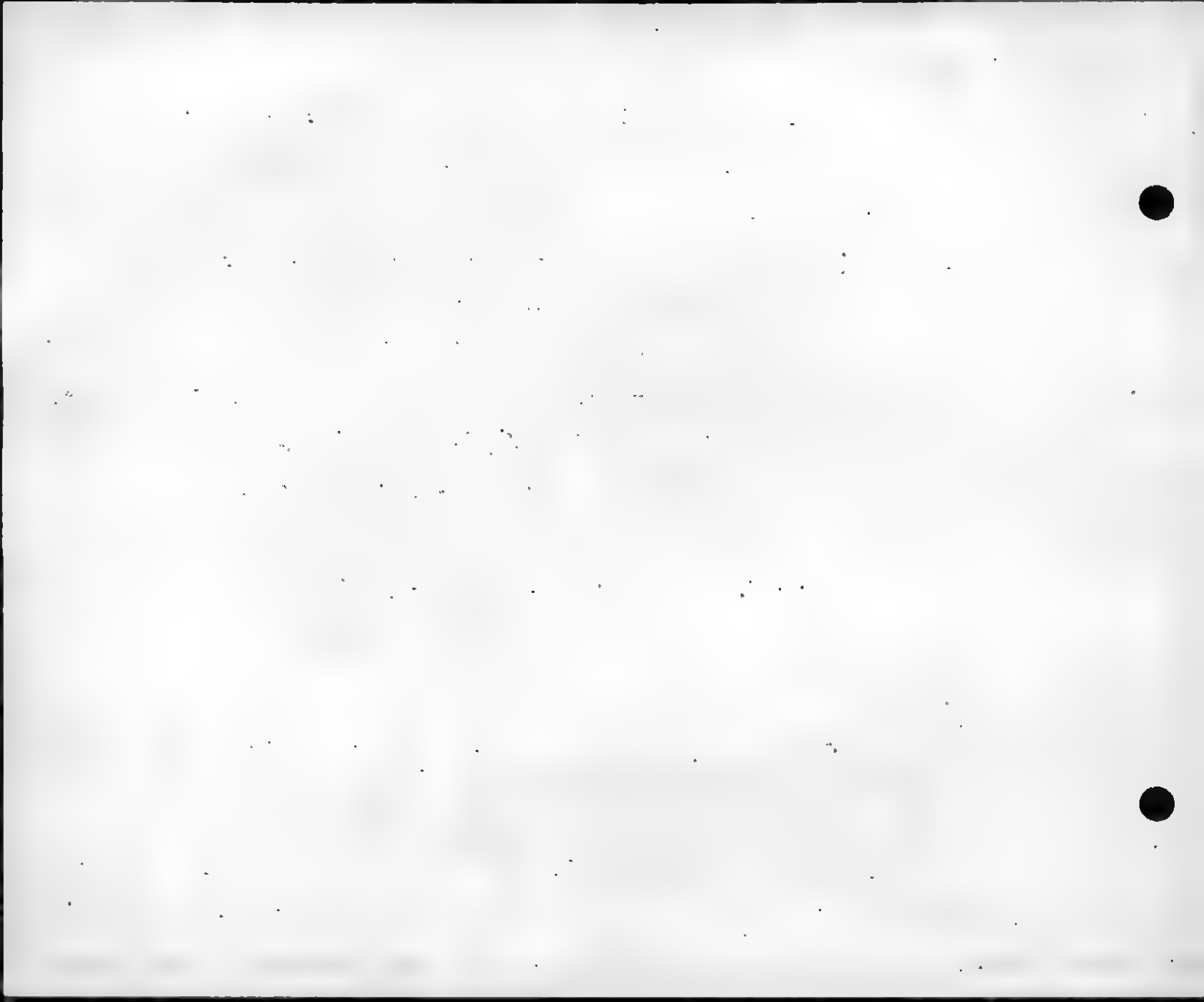
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00840

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) William Daniel Mason | | | 2a. DATE OF DEATH
Month January Day 14 Year 68 | | | 2b. HOUR
M | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
02-21-82 | | 6 AGE (In years lost birthday)
85 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md. | |
| 10. CITY OR TOWN OF DEATH
Cambridge (rural) | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Eastern Shore State Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Waterman and farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Maryland | | 13b. COUNTY
Somerset | | 13c. CITY OR TOWN
Deals Island | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
Charles Mason | | 15. MOTHER'S MAIDEN NAME First Middle Last
Virginia Thomas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
212-12-3146 | | 17. INFORMANT
Records of the Eastern Shore State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PROBABLE MASSIVE MYOC. INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c) 4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CHRONIC BRAIN SYNDROME; PULMONARY EMPHYSEMA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that he (this hospital) attended the deceased from 4-8- , 19 64 , to 1-14- , 19 68 , that (I) was lost saw the deceased alive on 1-14- , 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward Lewis MD | | | | DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS.
1-14-68 | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
EDWARD LEWIS, MD | | | | 22e. ADDRESS
ESSH, CAMBRIDGE, M.D. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
1-17-68 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. John's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Real Isl. Som. Md. | |
| 24. FUNERAL DIRECTOR
Leroy & Webb Princes Anny | | | | 25a. REC'D BY REGISTRAR
JAN 17 1968 | | 25b. REGISTRAR'S SIGNATURE
John Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

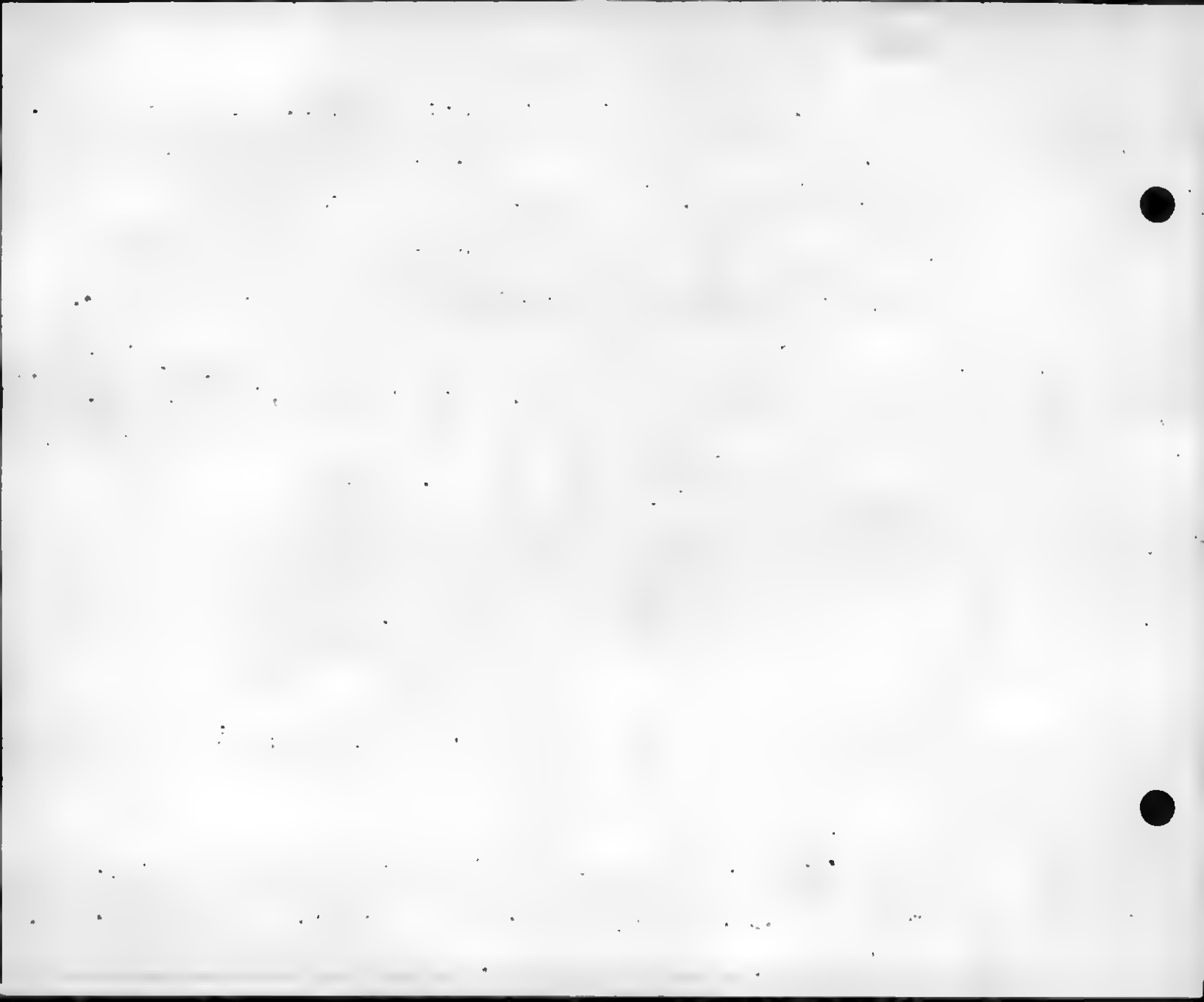
(M)

06842

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00841

| | | | | | |
|---|--|--|--|--|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Edna Willson Matthews | | | 2a. DATE OF DEATH
Month 27 Day 1968 | | 2b. HOUR
4P. M |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Aug. 17, 1879 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 6. AGE (In years last birthday) YRS
88 | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md | | | |
| 10. CITY OR TOWN OF DEATH
Hurlock | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Haven Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE
Maryland | | 13b. CITY OR TOWN
Dorchester | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13d. STREET AND NUMBER
307 West End Ave., | | 14. FATHER'S NAME First Middle Last
Ambrose Willson | | | |
| 15. MOTHER'S MAIDEN NAME First Middle Last
Sophie Houston | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
No | | | |
| 16b. SOCIAL SECURITY NO | | 17. INFORMANT
J. Emerson Matthews, Cambridge, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory viral disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>5272</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
12 days |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Serility</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 18</u> , 19 <u>67</u> , to <u>January 27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>January 27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Carlos F. Barroso MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type)
<u>CARLOS F. BARROSO MD</u> | | | | | 22e. ADDRESS
<u>C. Main Street, Hurlock Dorchester Md.</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
Jan. 30, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
East New Market Cemetery, East New Market, Md. | |
| 23d. LOCATION (City or Town) (County) (State)
Hurlock Dorchester Md. | | 24. FUNERAL DIRECTOR
<u>Kenneth P. Thomas</u> ADDRESS
Cambridge, Md. | | | |
| 25a. REC'D BY REGISTRAR
DATE FEB 1 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

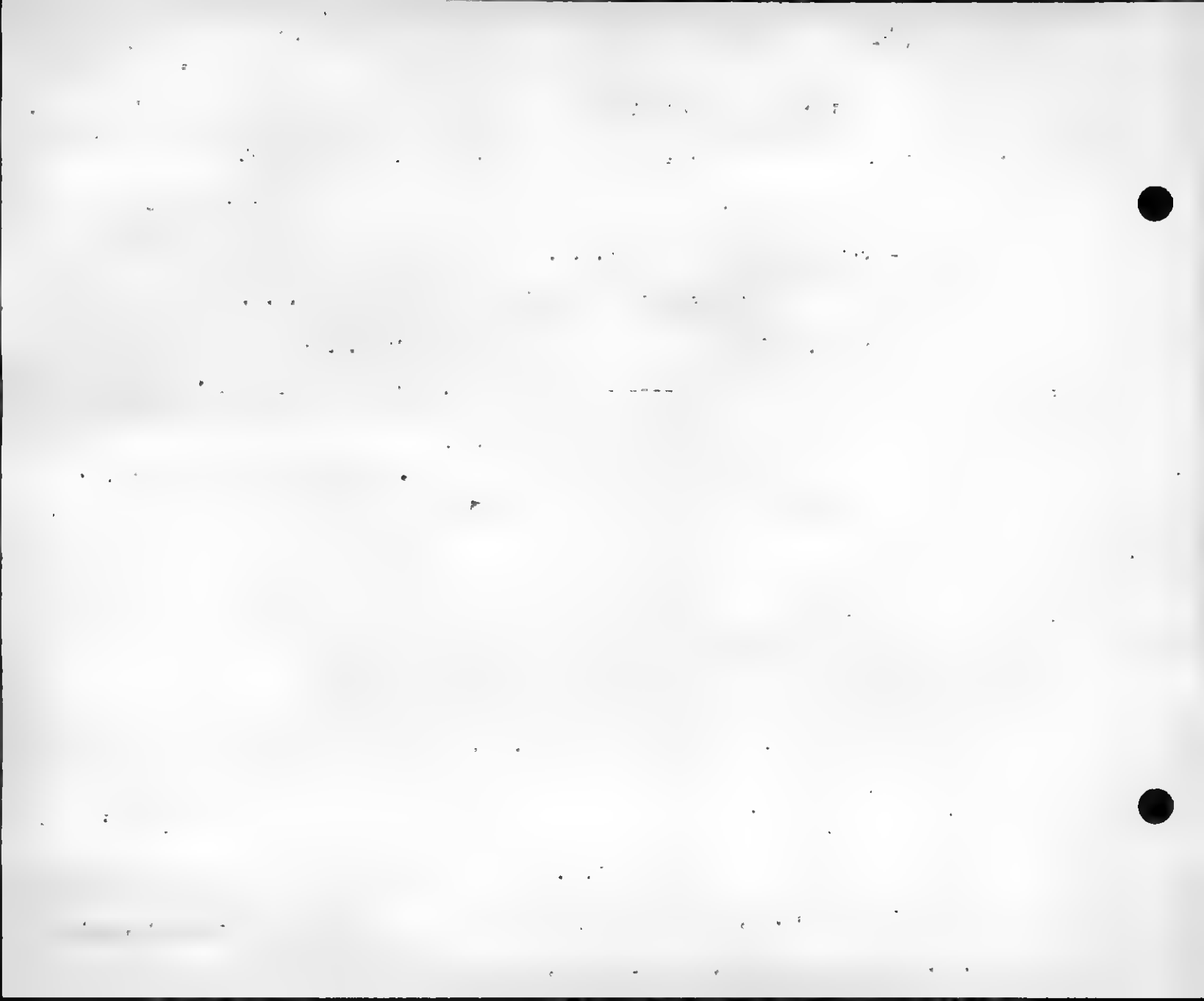
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00842

| | | | | | | | | | |
|--|--|---|---------------------------|---|--|---|--|--|----------------------------------|
| 1. DECEASED NAME
(Type or print) | | First
INDIA | Middle
CAROLINE | Last
MILLIGAN | 2a. DATE OF DEATH
Month January Day 13 Year 1968 | | 2b. HOUR
6 A. M. | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
July 20, 1899 | | 6. AGE (In years last birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester County Md | | | |
| 10. CITY OR TOWN OF DEATH
Hurlock - Rural | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
R.F.D. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housework | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
Maryland | | 13b. COUNTY
Dorchester | | 13c. CITY OR TOWN
Hurlock | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
R.F.D. | |
| 14. FATHER'S NAME
First Oscar L. Middle Milligan Last Oscar L. Milligan | | | | 15. MOTHER'S MAIDEN NAME
First Edith H. Middle Medford Last Edith H. Medford | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
----- | | 17. INFORMANT
Name Ralph C. Milligan Address Hurlock, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinomatosis
11 yrs
DUE TO, OR AS A CONSEQUENCE OF Carcinoma of the breast right
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 170x
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 yrs | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypothyroidism 25 yrs | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4.24. , 19 59 , to 1/13 , 19 68 , that (I) (we) last saw the deceased alive on 1.8/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harold B. Flummer | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
1/13/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Harold B. Flummer M.D. | | | | 22e. ADDRESS
Preston Maryland | | | | | |
| 23a. BURIAL, CREMATION, or other disposition
Burial | | 23b. DATE
Jan. 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hurlock, Maryland, Dorchester | | | |
| 24. FUNERAL DIRECTOR
J. J. Frampton and Son, Federalburg, Maryland | | | | ADDRESS
Federalburg, Maryland | | 25a. REC'D BY REGISTRAR
JAN 19 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PM-3". Page 5 may be retained for your files.

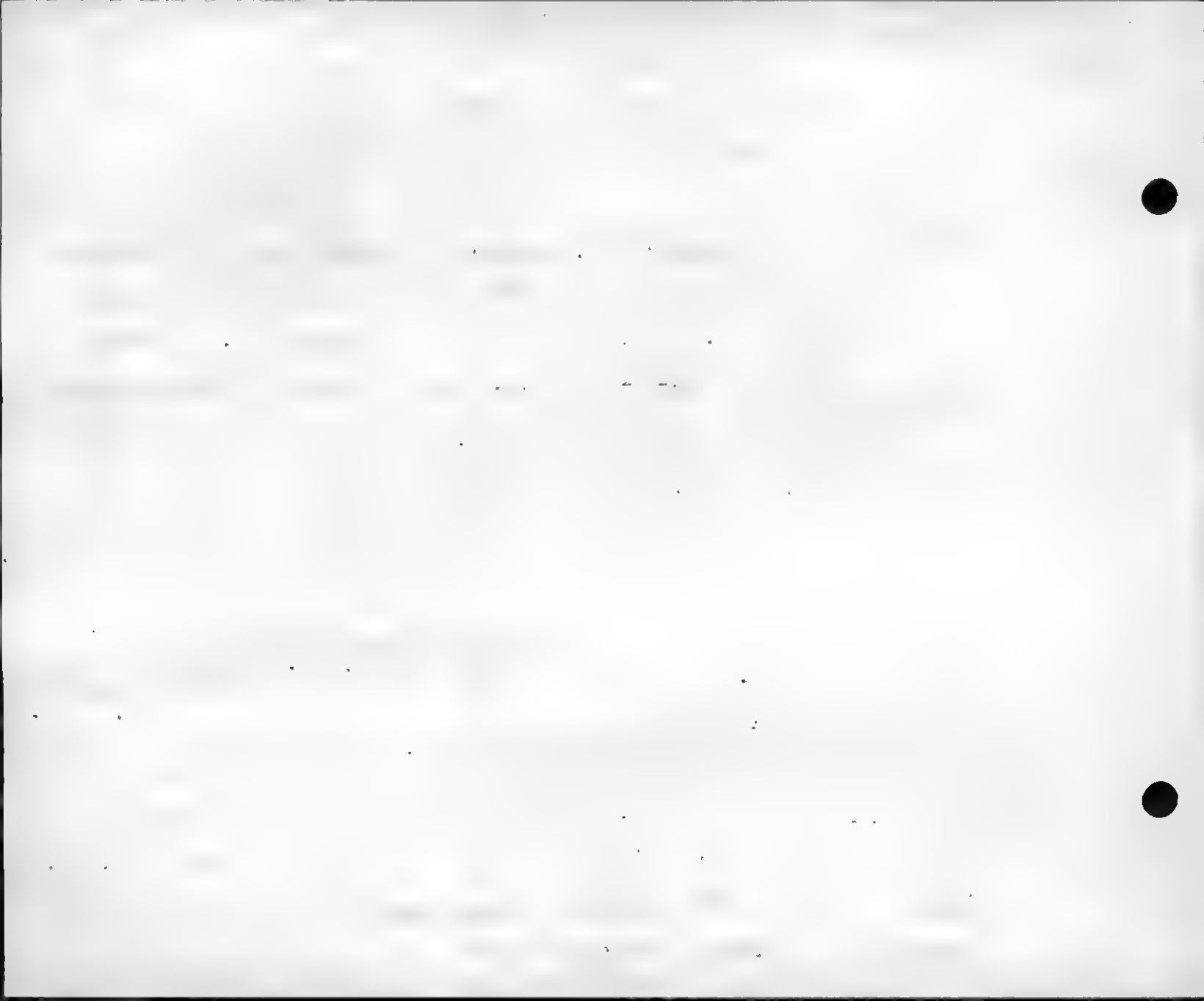
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00844

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00843

| | | | | | | | | | | | | | | | | | | | |
|--|--|--------|-------------------|--|--|--|--|---|----------------|------------------------------|--|---|--|--|----------|-----------------------|--|--|--|
| 1 DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN
OF ESTI-
DEATH MATED | | | Month Day Year | | | 2b HOUR | | | | | | | |
| HOBART | | | THOMAS | | | MILLS | | | Jan 26 19 68 | | | M | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR | | | | |
| Male | | White | | July 21 1899 | | 68 YRS | | | | | | 19 | | | M | | | | |
| 7a BIRTHPLACE (State or foreign
country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | |
| Maryland | | | | USA | | | | | | | | Dorchester | | | | Md | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| Toddville | | | | DOA
Cambridge Md. Hospital | | | | Seafood Packer | | | | Seafood | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before
admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 3d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e STREET AND NUMBER | | | |
| Md | | | | Dorchester | | | | Toddville | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | None | | | |
| 14. FATHER'S NAME | | | | First Middle Last | | | | 15 MOTHER'S MAIDEN NAME | | | | First Middle Last | | | | | | | |
| Millard | | | | A. Mills | | | | Missouri | | | | V. Cannon | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service) | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| No | | | | 249-28-8286 | | | | Mrs. Hobart T. Mills, Toddville, Maryland | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Crushing wound of chest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| | | | | | | | | | | | | ? | | | | | | | |
| | | | | | | | | | | | | ? | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day Year
HOUR AM | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or RFD No City or Town County State | | | | | | | | | | | |
| | | | | Highway | | | | Toddville Dor. Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION
REMOVAL (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | Jan 28 1968 | | | | Dorchester Memorial Park | | | | Cambridge, Maryland | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a REC'D BY REG STRAR | | | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| LeCompte Funeral Service, Cambridge, Maryland | | | | | | | | FEB 7 1968 | | | | judge | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|--|--------|--|--------------------------------|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | |
| OSCAR | | | | | | | MURPHY | | Month JAN Day 22 Year 1968 | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | 7. UNDER 1 YEAR | | |
| M | | W | | JULY 3, 1988 | | | 77 YRS. | | IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | |
| MD | | USA | | WIDOWED | | DIVORCED | | DORCHESTER | | Md | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| HURLOCK | | | BELL ST. APT 2 | | | FARM | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| MD | | | CAROLINE | | | DENTON | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| WILLIAM MURPHY | | | ANDREWS | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| NO | | | | | | WALTER MURPHY | | | Spartanburg, Del. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Bronchial Pneumonia | | | | | | | | | | 5 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Influenza ? Severe | | | | | | | | | | 5 days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Debility Arteriosclerosis General | | | | | | | | | | 10 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| Mild Diabetes Moderately Controlled Right Leg Amputated | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 10/2/50, 10/22/63 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/2/50, 19 10/22/63, that (I) (we) lost saw the deceased alive on 10/19/68, 19 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22c. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | | |
| Stac [Signature] | | | | | | | | 1/22/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | | |
| Harold B. Plummer M.D. | | | | | | | | Preston Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | Jan. 24, 1968 | | CONCORD | | CONCORD CAR. MD. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| CATHERINE V. MOORE DENTON MD. | | | | | | DATE JAN 26 1968 | | [Signature] | | | |



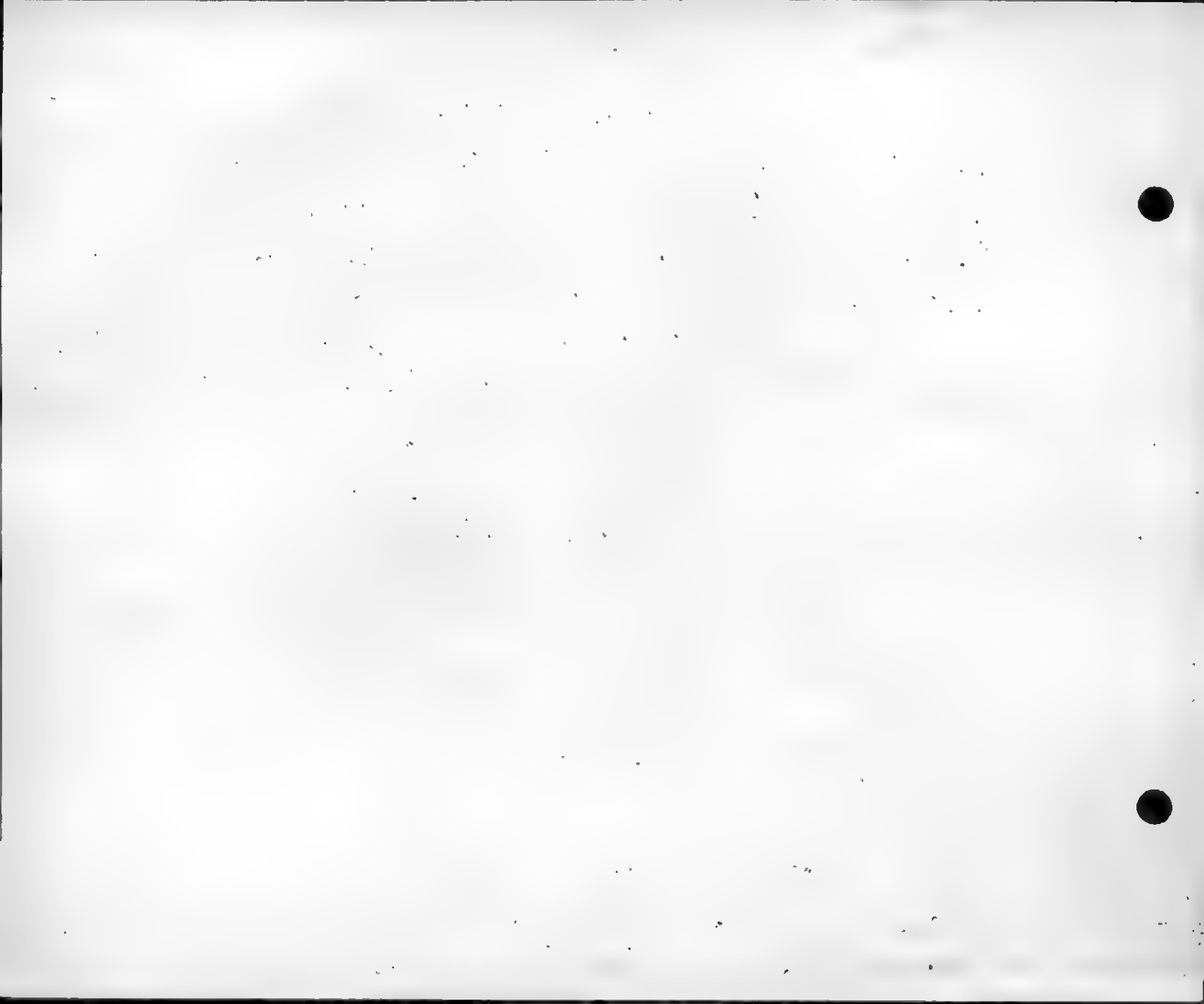
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

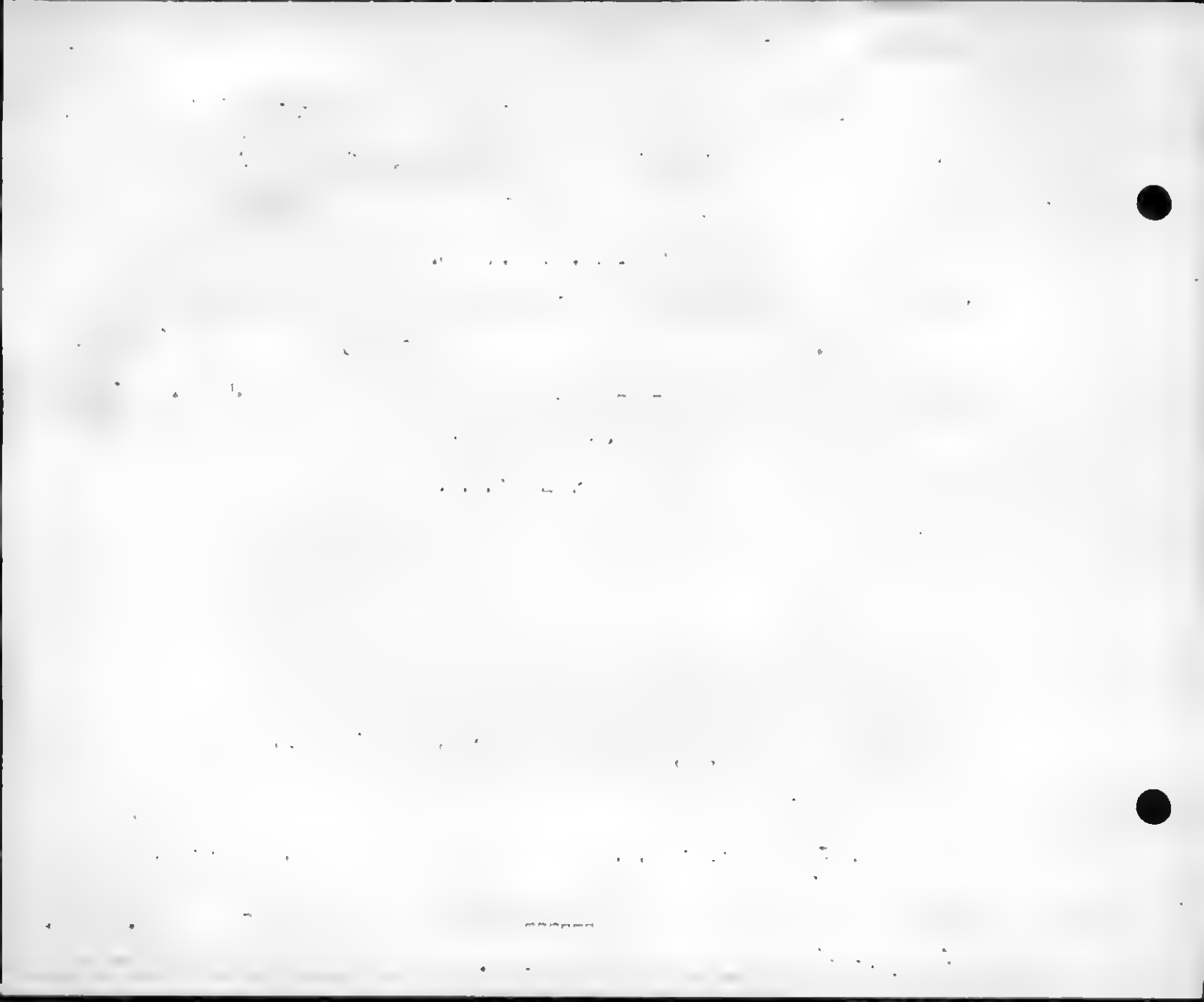
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 00846 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Olive | | | DAISY | | | OPATTA | | | Month Day Year 1 30 1968 | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | |
| Female | | | white | | | 7/25/1890 | | | 77 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Kent County Maryland | | | U.S.A | | | | | | Dorchester Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cambridge | | | Eastern Shore State Hosp | | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Maryland | | | Kent | | | Rock Hall | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Samuel | | | Collier | | | Gertrude | | | Pinkind | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Med. Records) Address | | | | | |
| UNKNOWN | | | 216-43 4812 | | | Eastern Shore State Hosp. Cambridge, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | | | | | | | | 10 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) CHRONIC BRAIN SYNDROME | | | | | | | | | | YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-30-1967, to 1-30-1968, that (I) (we) last saw the deceased alive on 1-30-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| Leandro M. Area M.D. | | | | | | | | | 1-30-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| LEONORO M. AREA | | | | | | EASTERN SHORES HOSPITAL. | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Feb. 1-68 | | | Wesley Chapel Cem | | | Rock Hill Kent Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| LECOMPT FURNAL SER. CAMBRIDGE MARYLAND | | | | | | DATE E-B 5 1968 | | | Charles Judge | | |

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 36841 | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | 00846 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
DAISEY PAYNE | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
JANUARY 5 1968 | | | | | | | | | | 2b. HOUR
2:15AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
FEMALE | | | | | | | | | | 4. RACE
NEGROID | | | | | | | | | | 5. DATE OF BIRTH
AUGUST 30, 1895 | | | | | | | | | | 6. AGE (In years last birthday) 72 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
DORCHESTER Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
CAMBRIDGE | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CAMBRIDGE MD. HOSP., INC. | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
LABORER | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MARYLAND | | | | | | | | | | 13b. CITY OR TOWN
DORCHESTER | | | | | | | | | | 13c. CITY OR TOWN
CAMBRIDGE | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER
610 DOUGLAS STREET | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
CHARLES PAYNE | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
JENNIE SEYMORE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
NO | | | | | | | | | | 16b. SOCIAL SECURITY NO
220-03-2007A | | | | | | | | | | 17. INFORMANT Address
NICIE ENNALS 507 DUNN'S CT. 21613 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 412.7 Cardiac decompensation
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic C.V.D.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1967, to Jan. 5, 1968, that (I) (we) last saw the deceased alive on Jan. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 1/6/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D. | | | | | | | | | | 22e. ADDRESS 625 HIGH Street, Cambridge, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | | | | | | 23b. DATE 1/8/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY BETHEL BETHEL | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) CAMBRIDGE DOR. MD. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR [Signature] | | | | | | | | | | ADDRESS CAMBRIDGE, MD. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE JAN 12 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

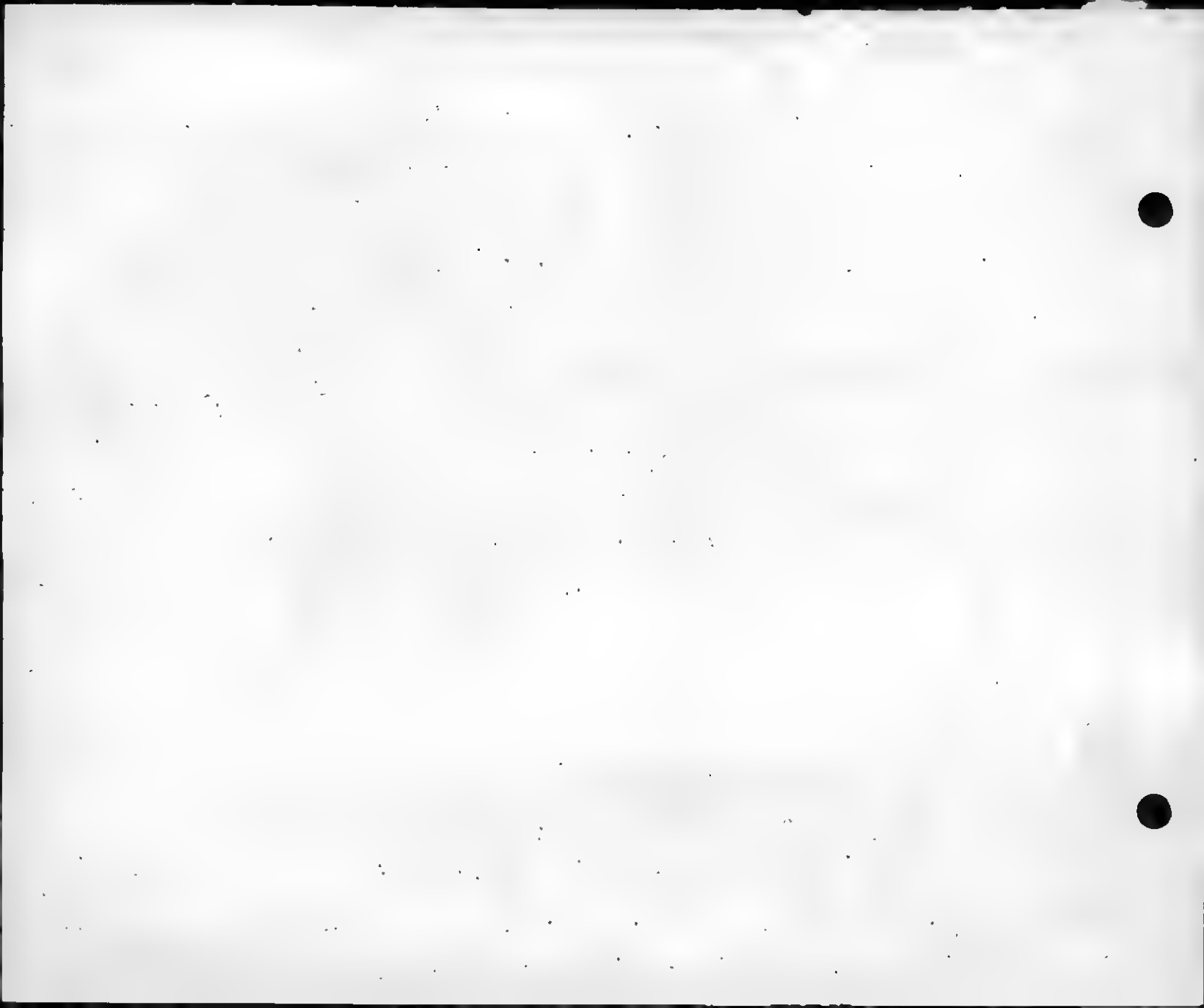
VR 10-68 (4)
30M REV 1/68

00843

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00847

| | | | | | | | | |
|--|--|--|--|---|--|--|------------------------|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| Mae | | M. | | POIK | 1-13-1968 | | 8 A M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 24 HRS | |
| Female | Colored | | 10-29-00 | | 67 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | U.S.A. | | | | Dorchester Md | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cambridge, Md. | Eastern Shore State Hosp | | Seaman | | | | | |
| 13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | Wic. Va. | | Valles, Md. | | | | Rt. #2 - Allen, Md. | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| Joseph | | | | Mitchell | Lidia (unknow) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no) or unknown | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address |
| | | | | | | Eastern Shore State Hosp. | | Camb. Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
7 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 7
(b) SEPTICEMIA.
DUE TO, OR AS A CONSEQUENCE OF
(c) MULTIPLE DECUBITUS ULCERS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
1 WK.
1 MONTH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
CACHEXIA, CEREBRAL THROMBOSIS, SYPHILIS, CHRONIC BRAIN SYNDROME. | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 12, 1967, to JAN 13, 1967, that (I) (we) last saw the deceased alive on JAN 13, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Sean M. Killoran M.D. | | | | | | 22c. DATE SIGNED
JAN 13, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
SEAN M. KILLORAN | | | | | | 22e. ADDRESS
7415 BLAIR ST. WASHINGTON, D.C. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | 1-16-68 | | GREEN ACRES | | Salisbury Wic. Md. | | |
| 24. FUNERAL DIRECTOR
Jolly H. Home | | | | ADDRESS
Jensen Road | | 25. REC'D BY REGISTRAR
JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |



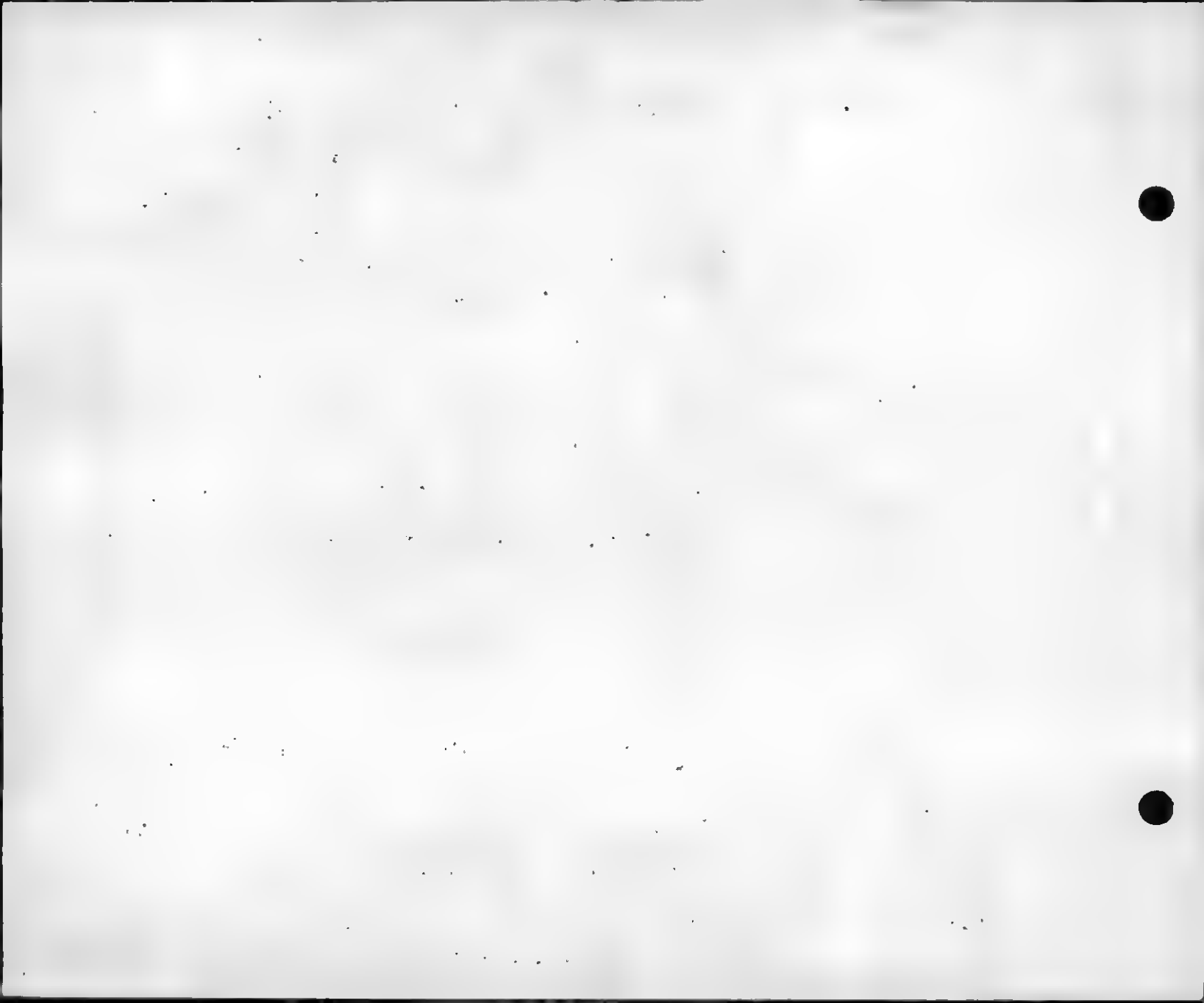
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|---|--|--|---|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 00849 | | | | | | | | | | |
| 00848 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
BERTHA ANELDA REDDEN | | | | | 2a. DATE OF DEATH
Jan 21 1968 | | 2b. HOUR
M | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
JULY 25, 1889 | | 6. AGE (In years last birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
DORCHESTER Md. | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERLOCK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
BELLEHAVEN NURSING | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
at home | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
MD | | | 13b. COUNTY
DORCHESTER | | 13c. CITY OR TOWN
RIDGELY | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last
SMITH | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT
MARION REDDEN Address
RIDGELY MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Influenza Type ?</u>
fion
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Above with debility (obesity and uncontrolled</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes, Also Auricular Fibrillation</u>
10yrs | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
fion | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/10/50</u> , 19__, to <u>1/21/68</u> , 19__, that (I) (we) last saw the deceased alive on <u>1/19/68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harold Plummer M.D.</u> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
1/24/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Harold Plummer M.D. | | | | | 22e. ADDRESS
I.C. Box #158 Preston Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
JAN 25, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
DENTON | | 23d. LOCATION (City or Town) (County) (State)
DENTON CAR. MD. | | | | |
| 24. FUNERAL DIRECTOR
CHARLES V. MOORE, DENTON MD. | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 29 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

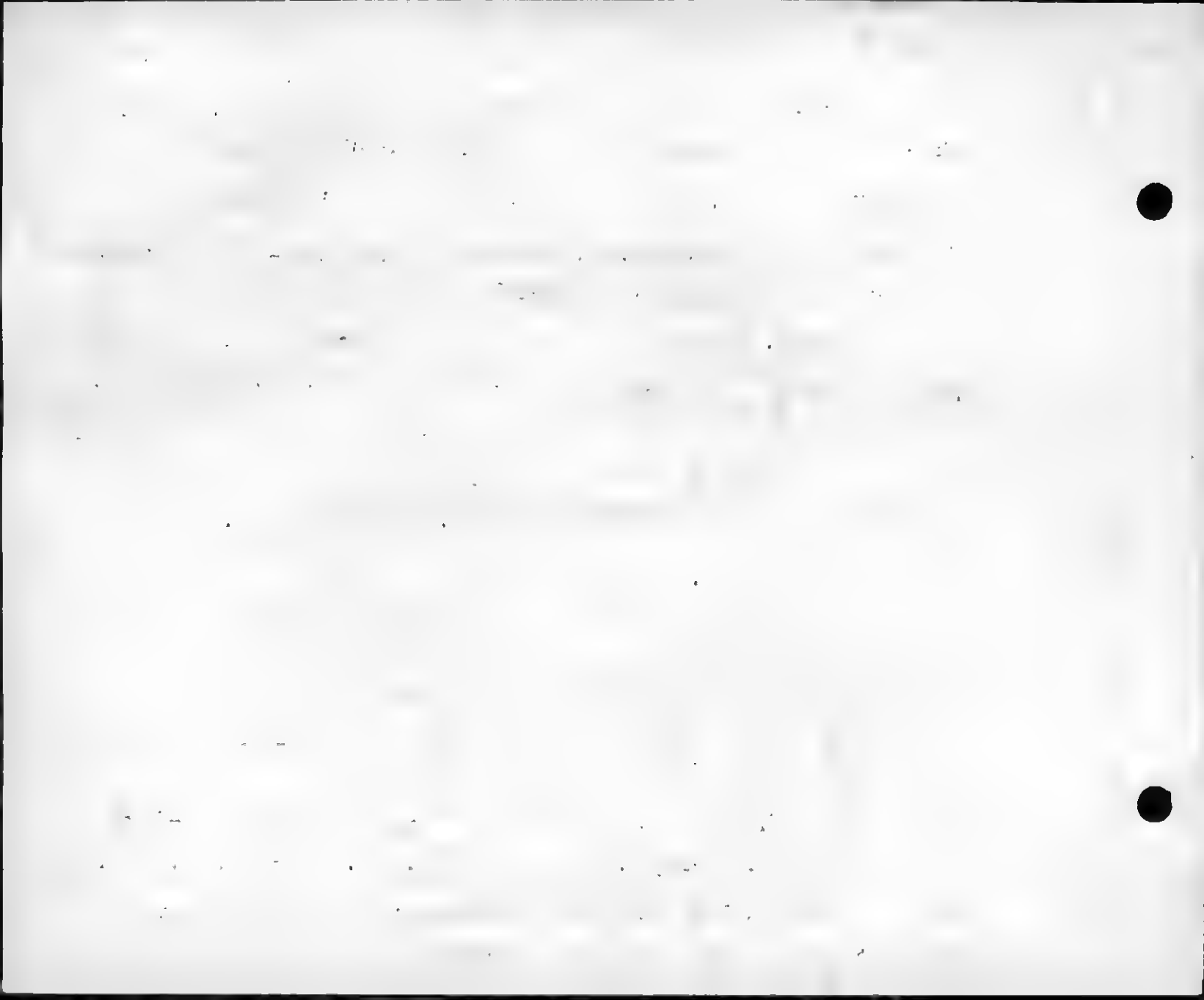
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|---------------------|--|---|---|----------------------|
| 00850 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 00849 | |
| 1 DECEASED NAME
(Type or print) | | First
THOMAS | Middle
C. | Last
RIPPONS | 20. DATE OF DEATH
Month Jan. Day 24 Year 1968 | | 2b. HOUR
M |
| 3. SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
March 28, 1892 | | 6. AGE (In years last birthday)
75 YRS. | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Dorchester | |
| 10 CITY OR TOWN OF DEATH
Cambridge | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cambridge Md. Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Waterman - Ret | | 12b KIND OF BUSINESS OR INDUSTRY
Seafood | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md | | 13b COUNTY
Dorchester | | 13c CITY OR TOWN
Hoopersville | | 13d INSIDE CITY LIM 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME
First Thomas L. Middle Rippons Last | | 15. MOTHER'S MAIDEN NAME
First Anna Middle Tyber Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) Yes (If yes give war or dates of service) WW I | | | |
| 16b. SOCIAL SECURITY NO
unk | | 17 INFORMANT
Mrs. Benjamin Parks, Hoopersville, Md. | | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROSIS
(c) CORONARY HEART DISEASE with Auricular Fibrillation | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12-30-67 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIABETES MELLITUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-31-67 , 19 67 , to 1-24-68 , 19 68 , that (I) (we) last saw the deceased alive on 1-24-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Albert E. Bunker, M.D. | | 22c. DATE SIGNED
1-26-68 | | 22d. PHYSICIAN'S NAME (Type)
ALBERT E. BUNKER, M.D. | | | |
| 22e. ADDRESS
200 Md. Ave., Cambridge, Md. 21613 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan 27, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Cambridge, Maryland | |
| 24 FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE
W. J. Yager | |

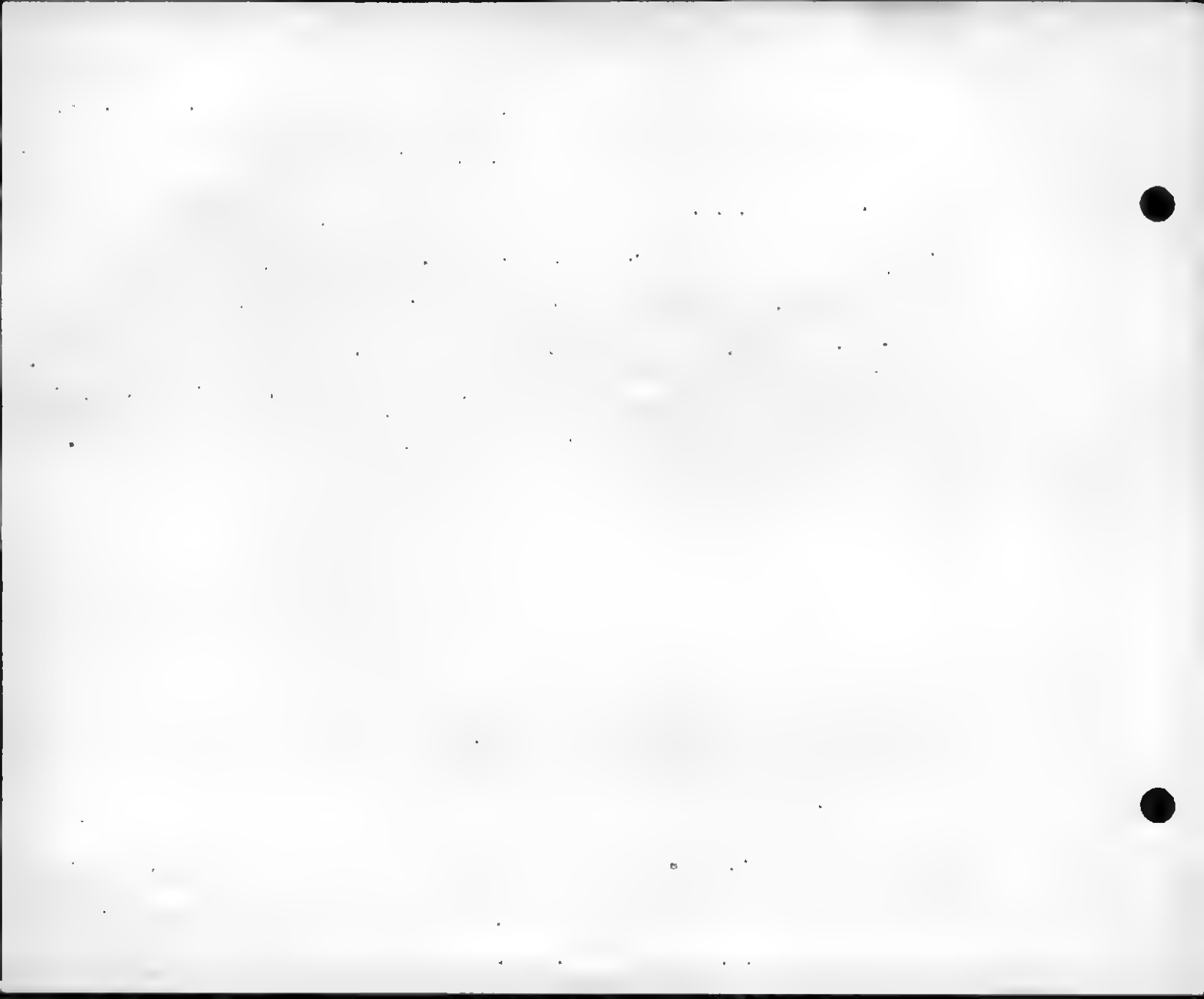


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| <div>36851</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>00850</div> | | | | | | | | | | | | | | | |
|---|--|------------------------------|--|---|--|--|--|--|--|--|--|--|--|----------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Robinson | | | | January 27 | | | | Month Day Year | | | | 68 5:30 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | | White | | January 27, 1968 | | | | YRS. | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | | | Dorchester Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cambridge | | | | Cambridge Maryland Hosp. | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | | Talbot | | Easton | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 120 N. Harrison St. Aurora/St. Michaels | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | | | |
| Robert Meade Robinson | | | | Arlene Muddle | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | | | |
| Yes, no, or unknown | | | | | | Mother 120 N. Harrison St. Easton Md | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>777X</u> <u>sliminess</u> | | | | | | | | | | | | 1 Hr | | | |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | |
| 21a. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town | | County State | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 27, 1968, to January 27, 1968, that (I) (we) last saw the deceased alive on January 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | 22c. DATE SIGNED | | | |
| <u>Dr. Elbur N. Baumann</u> | | | | | | | | | | | | 1-29-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Elbur N. Baumann | | | | | | | | | | | | 22e. ADDRESS | | | |
| | | | | | | | | | | | | 10 Aurora St Cambridge, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| X | | | | January 27, 68 | | Cambridge Md. Hospital | | | | Cambridge Dorchester Maryland | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | | 25a. REC'D BY REG. STRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Katherine Williams K.N. Cambridge, Md. Hosp. | | | | | | | | | | | | DATE JAN 31, 1968 | | <u>Charles J. J...</u> | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

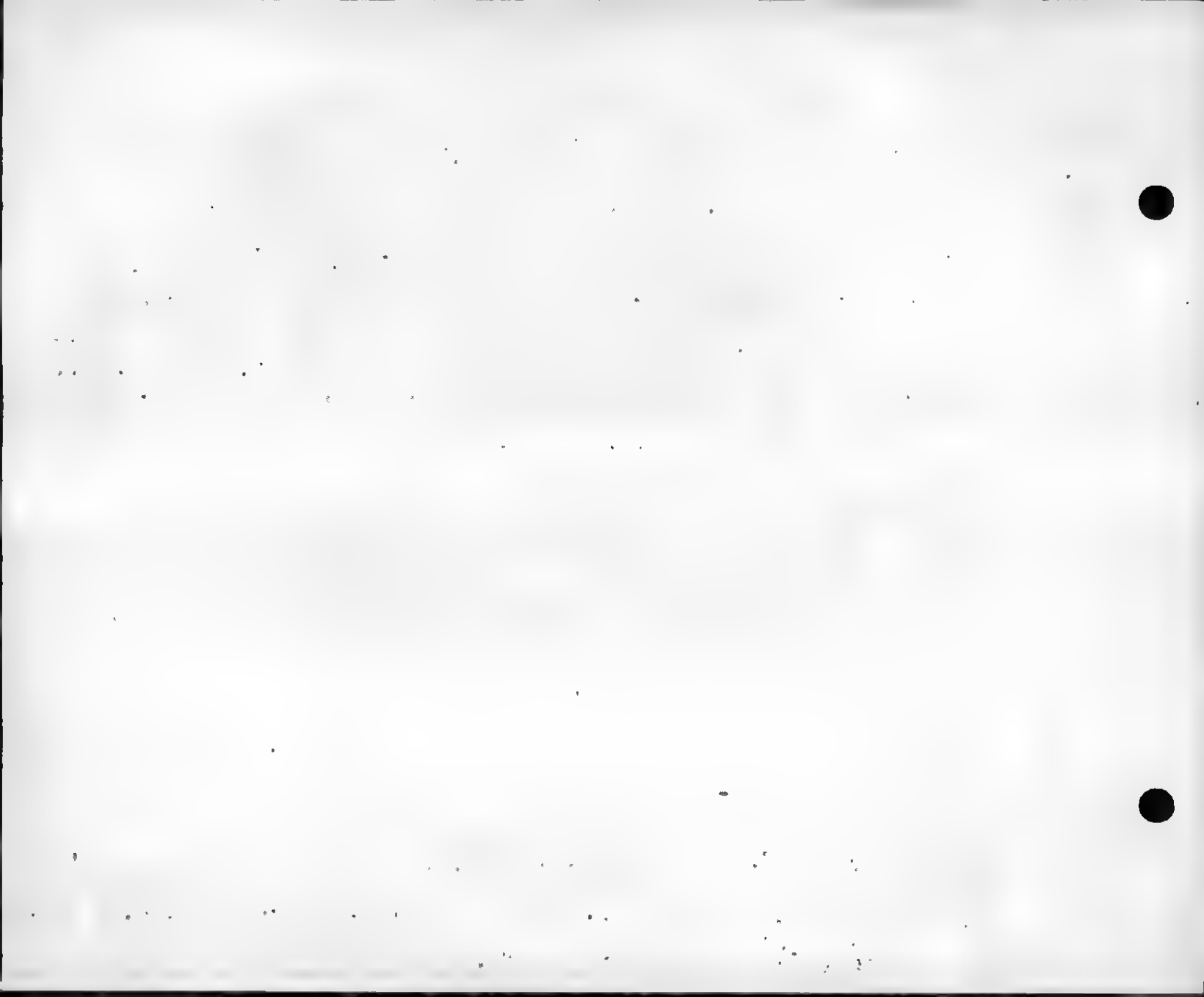
| | | | | | | | | | | | |
|---|------------------------|--|--|--|--|--|--|---|--|---|--|
| 1 DECEASED-NAME
(Type or Print) | | First
ELLA | | Middle
KIRTLEY | | Last
ROWLISON | | 2a DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Jan 24 1968 | | 2b HOUR
3 A M | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
June 24 1876 | 6 AGE
91 years
(last birthday)
91 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | | 2c DATE PRONOUNCED DEAD
Month Day Year 19 | | 2d HOUR
M | |
| 7a BIRTHPLACE (State or foreign country)
Kentucky | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Dorchester | | | | | |
| 10 CITY OR TOWN OF DEATH
Cambridge | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1001 Hambrooks Blv'd | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md | | 13b COUNTY
Dorchester | | 13c CITY OR TOWN
Cambridge | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
1001 Hambrooks Blv'd. | | | |
| 14 FATHER'S NAME
First
John | | Middle
? | | Last
Kirtley | | 15 MOTHER'S MAIDEN NAME
First
Emma | | Middle
? | | Last
Nuchols | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b SOCIAL SECURITY NO.
(If yes give war or dates of service)
unk | | 17 INFORMANT
ADDRESS
Mrs. Tawes Insley, Cambridge, Maryland | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Instant | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
7-11 | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 2a EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21a INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
John Mace Jr. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b DATE SIGNED
1/25/68 | | | |
| EXAMINER'S NAME (Type)
John Mace Jr. M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | ADDRESS (Street, city, town, or county)
Cambridge, Md. | | | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
Jan 26, 1968 | | 23c NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park | | 23d LOCATION (City or Town) (County) (State)
Cambridge, Maryland | | | | | |
| 24 FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | | | 25a REC'D BY REGISTRAR
DATE JAN 29 1968 | | 25b REGISTRAR'S SIGNATURE
Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

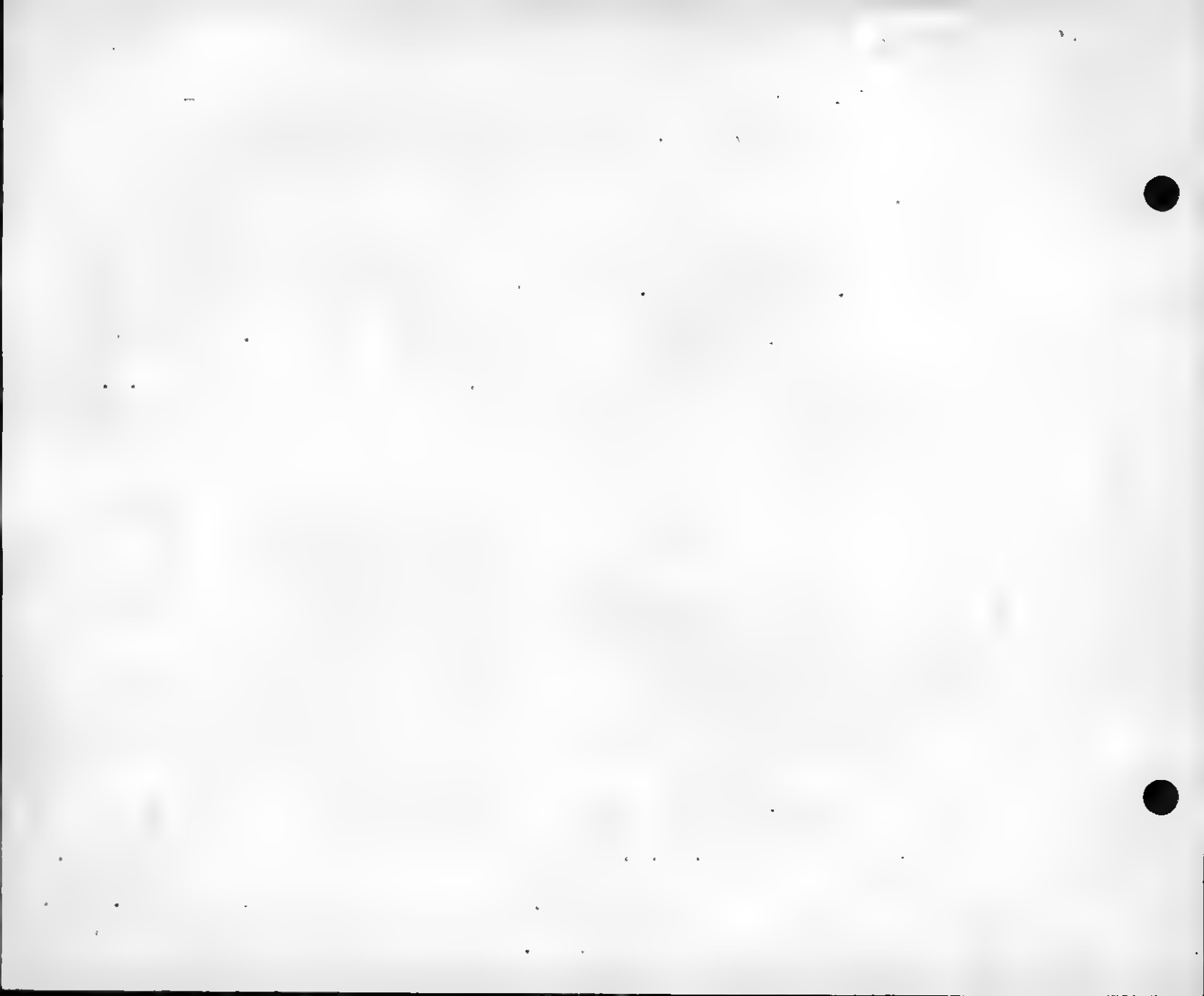
| 00853 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 00852 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR P.M. | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | |
| Alverta Meekins Ruark | | | | | | | | | | 1/16/68 | | | | | | | | | | 12:45 | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR | | | | | IF UNDER 24 HRS | | | | | | | | | |
| Female | | | | | White | | | | | Apr. 14, 1880 | | | | | 67 | | | | | MONTHS DAYS | | | | | HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | U.S. | | | | | | | | | | Dorchester Md | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Cambridge | | | | | Cambridge-Maryland Hosp. Home-maker | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | |
| Maryland | | | | | Dorchester | | | | | Cambridge | | | | | YES | | | | | 400 Cedar St. | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| John G. Meekins | | | | | Margaret Ann Ruark | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 402 E. Appleby Ave.,
Bernie M. Ruark, Cambridge, Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARLINOVA OF ABLTUM & OBSTRUCTION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 154.1 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-9, 1968, to 1-16, 1968, that (1) (we) lost saw the deceased alive on 1-16, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE James F. McCarter | | | | | | | | | | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 1-17-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) James F. McCarter, M.D. | | | | | | | | | | | | | | | 22e. ADDRESS P.O. Box 386 Cambridge, Maryland | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | | | | | | 23b. DATE Jan. 18, 1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Md. | | | | | | | | | |
| 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. READ BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Kenneth R. Thomas | | | | | | | | | | | | | | | Cambridge, Md. | | | | | | | | | | JAN 22 1968 | | | | | Charles Judge | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-5. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | First
Carolyn | | Middle
Rita | | Last
Schlee | | 2a DATE KNOWN
OF EST. DEATH | | 2b HOUR
Month Day Year 1968 ? M | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
4/1/1893 | | 6 AGE (In years last birthday)
74 7/8 YRS | | 7c DATE PRONOUNCED DEAD
Month Day Year 1968 2:10 PM | | 2d HOUR
Month Day Year 1968 2:10 PM | |
| 7a BIRTHPLACE (State or foreign country)
N.J. | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md. | | | | | |
| 10 CITY OR TOWN OF DEATH
Secretary | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY
Home | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md. | | 13b COUNTY
Dor. | | 13c CITY OR TOWN
Secretary | | 3a INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
Rural | | | |
| 14. FATHER'S NAME
First Middle Last
William H. Hangs | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Katie B. Sonnefeld | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Mrs. John Forder | | ADDRESS
Durham, N.C. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Instant | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | John Mace Jr. M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASS STANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED
1/13/68 | | Cambridge, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE
1/13/68 | | 23c NAME OF CEMETERY OR CREMATORY
Dor. Memorial Park | | 23d LOCATION (City or Town) (County) (State)
Cambridge, Dor. Md. | | | | | |
| 24. FUNERAL DIRECTOR
R. Howard | | ADDRESS
Cambridge, Md. 21613 | | 25a REC'D BY REGISTRAR
DATE
JAN 16 1968 | | 25b REGISTRAR'S SIGNATURE
R. Howard | | | | | |



30855

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

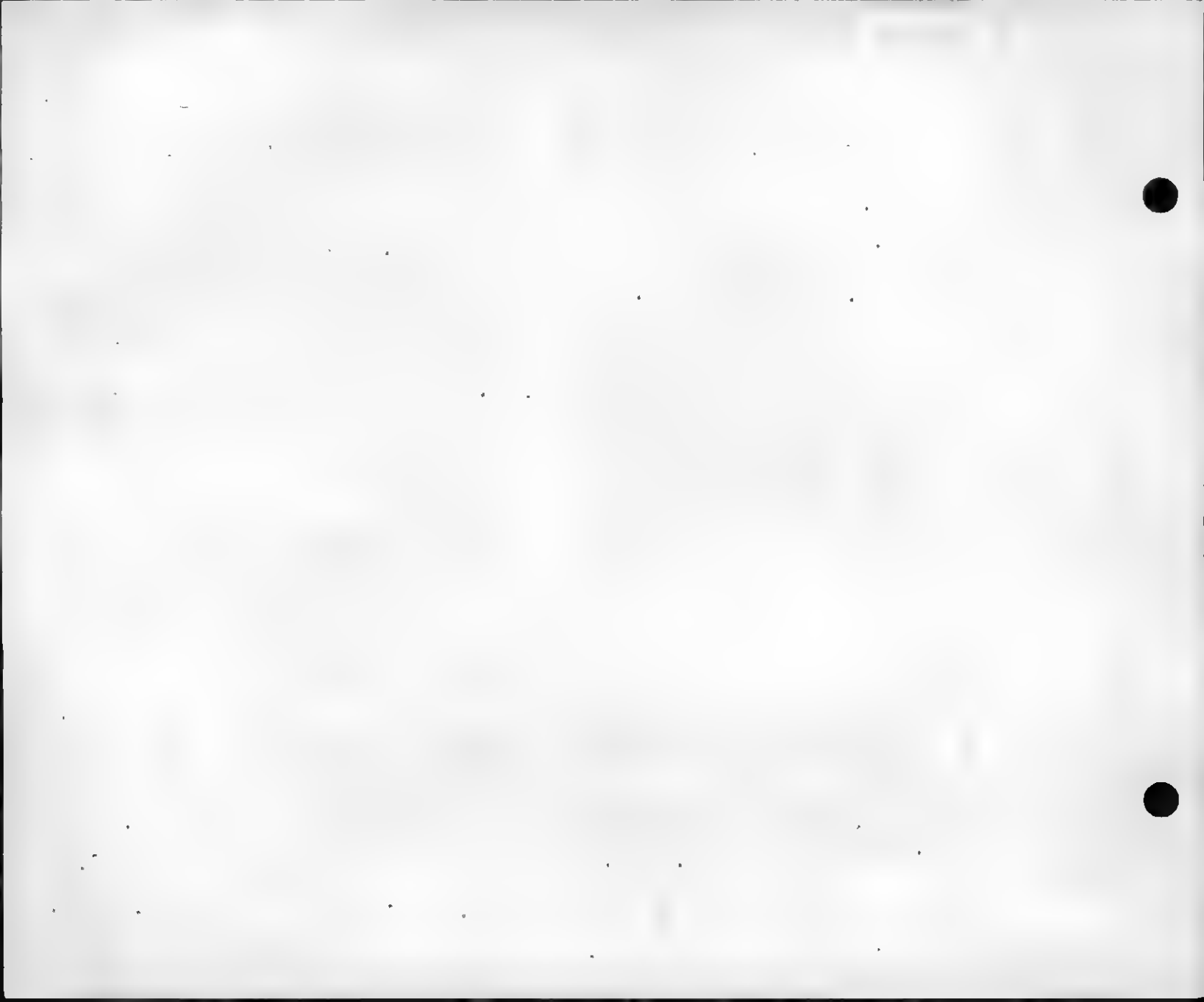
00854

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|---|--|--|--|---|----------------|------------------------------|--|---|--|---------------------------------|------------------|-------------------------|--|
| 1. DECEASED NAME
(Type or Print) | | | First
Walter | | | Middle
Ernest | | | Last
Schlee | | | 2a. DATE KNOWN OF DEATH
Month Day Year
1-11-1968 | | | 2b. HOUR
? M | | |
| 3 SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
2/22/1884 | | 6. AGE (In years last birthday)
83 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS | | 7. UNDER 24 HRS
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year
1 11 1968 | | | 2d. HOUR
2:35 | | |
| 7a. BIRTHPLACE (State or foreign country)
Mass. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Dorchester Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Secretary | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Plumber | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE
Md. | | | | 13b. COUNTY
Dor. | | | | 13c. CITY OR TOWN
Secretary | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rural | | | |
| 14. FATHER'S NAME
First Middle Last
William Schlee | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Ida Wydel | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service) | | | | 17. INFORMANT
Mrs. John Forder | | | | | | | | ADDRESS
Durham, N.C. | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Instant | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
John Mace Jr. M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
1/13/68
ADDRESS (Street, city, town, or county) Cambridge, d. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
1/13/68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Mem. Park | | | | 23d. LOCATION (City or Town) (County) (State)
Cambridge, Dor., Md. | | | | | |
| 24. FUNERAL DIRECTOR
Kenneth P. Hickey | | | | ADDRESS
Cambridge, Md. 21613 | | | | 25a. REC'D BY REGISTRAR
JAN 16 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

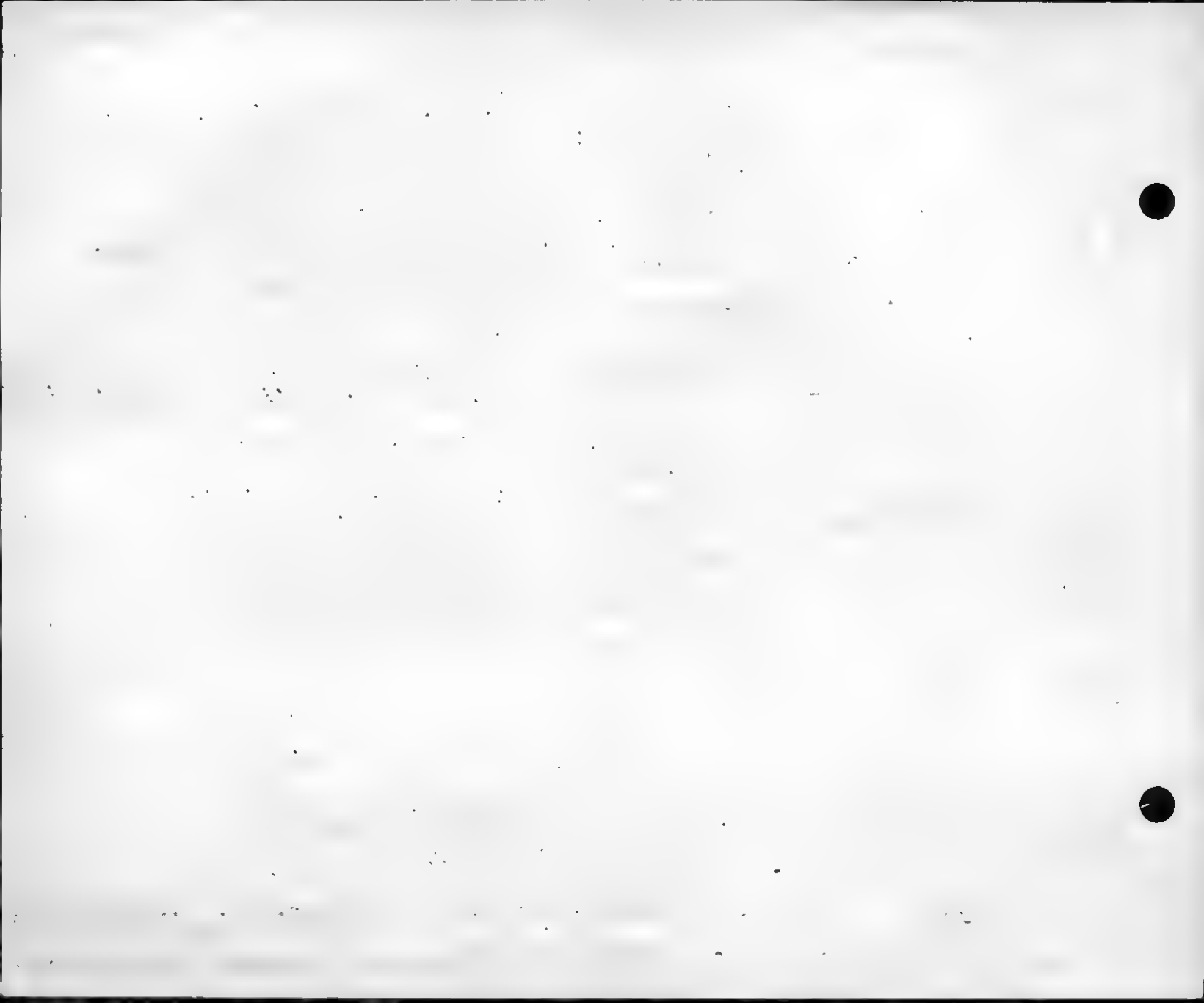
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00856

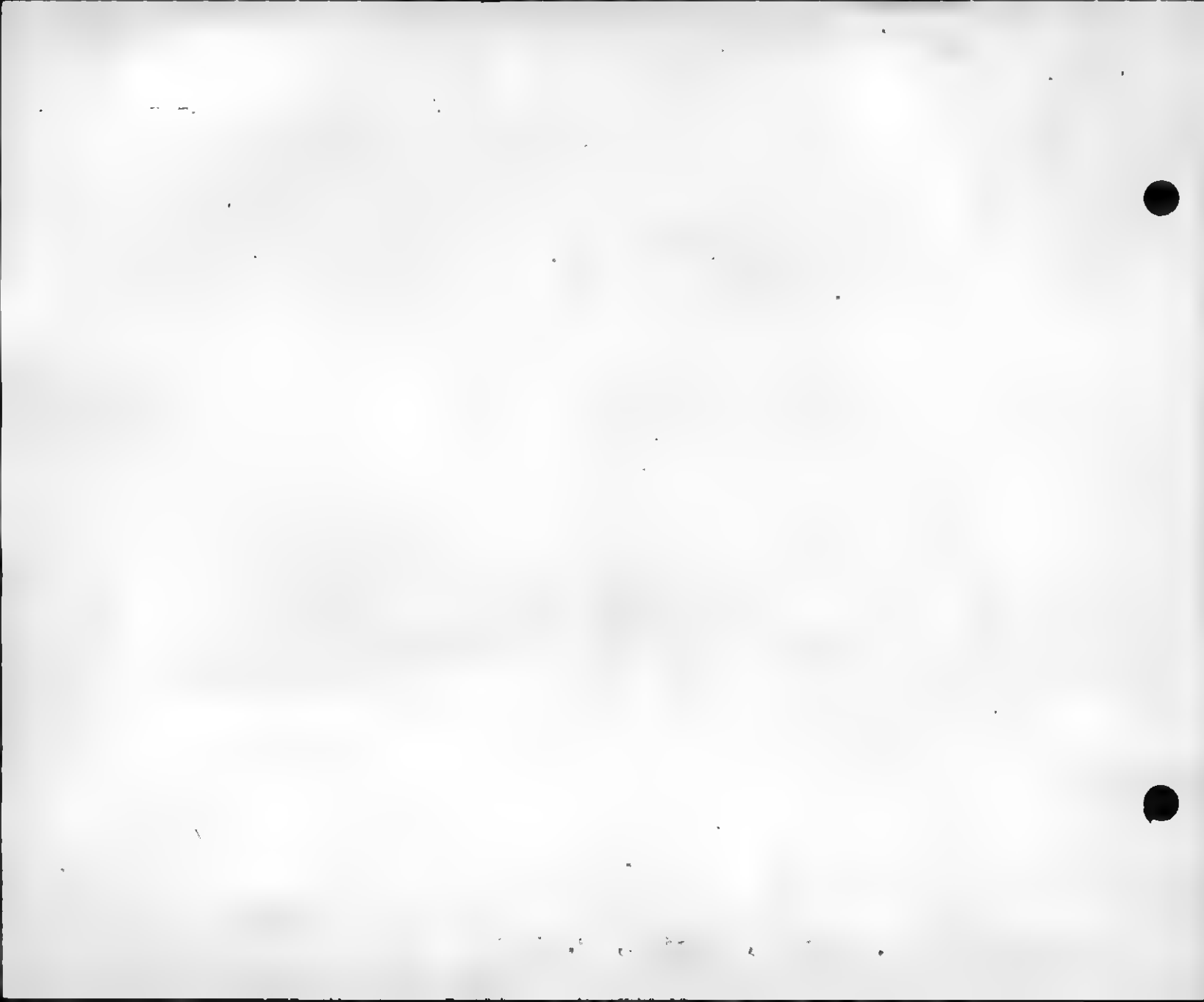
00855

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(Type or print) Benjamin H Seward | | | 2a. DATE OF DEATH
Month 7 Day 26 Year 1968 | | | 2b. HOUR
1 A.M. | | | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
7-22-96 | | 6. AGE (In years last birthday)
71 YRS | | 7. UNDER 1 YEAR
MONTHS 1 DAYS 1 HOURS 1 MINS | | | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester | | | X MD. | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Eastern Shore State Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CARPENTER | | | 12b. KIND OF BUSINESS OR INDUSTRY
General | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD. | | | 13b. COUNTY
Dorchester | | 13c. CITY OR TOWN
R.D. 3 | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
None | | |
| 14. FATHER'S NAME First Middle Last
THOMAS EDWARD SEWARD | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
SUSIE EMILY HUBBARD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
214-07-7206 | | 17. INFORMANT (Indicate records)
Eastern Shore State Hosp. | | | Address
Cambridge, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 412.0 Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. complicated by bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) 443.2 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
443.2 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-7- 19 64 , to 1/26 19 68 , that (I) (we) last saw the deceased alive on 1/26 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John W. Rieckert | | | | | | DEGREE
MD. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-26-68 | |
| 22d. PHYSICIAN'S NAME (Type)
John W. Rieckert | | | | | | 22e. ADDRESS
E-New Market, MD | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION (specify)
Burial | | 23b. DATE
Jan 29, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Spedden-Seward Cemetery | | 23d. LOCATION (City or Town) (County) (State)
James, Dor. Co., Maryland | | | | | |
| 24. FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | | | | | ADDRESS
Cambridge, Maryland | | 25a. REC'D BY REGISTRAR
DATE 29 1968 | | 25b. REGISTRAR'S SIGNATURE
J. J. J. | |



TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

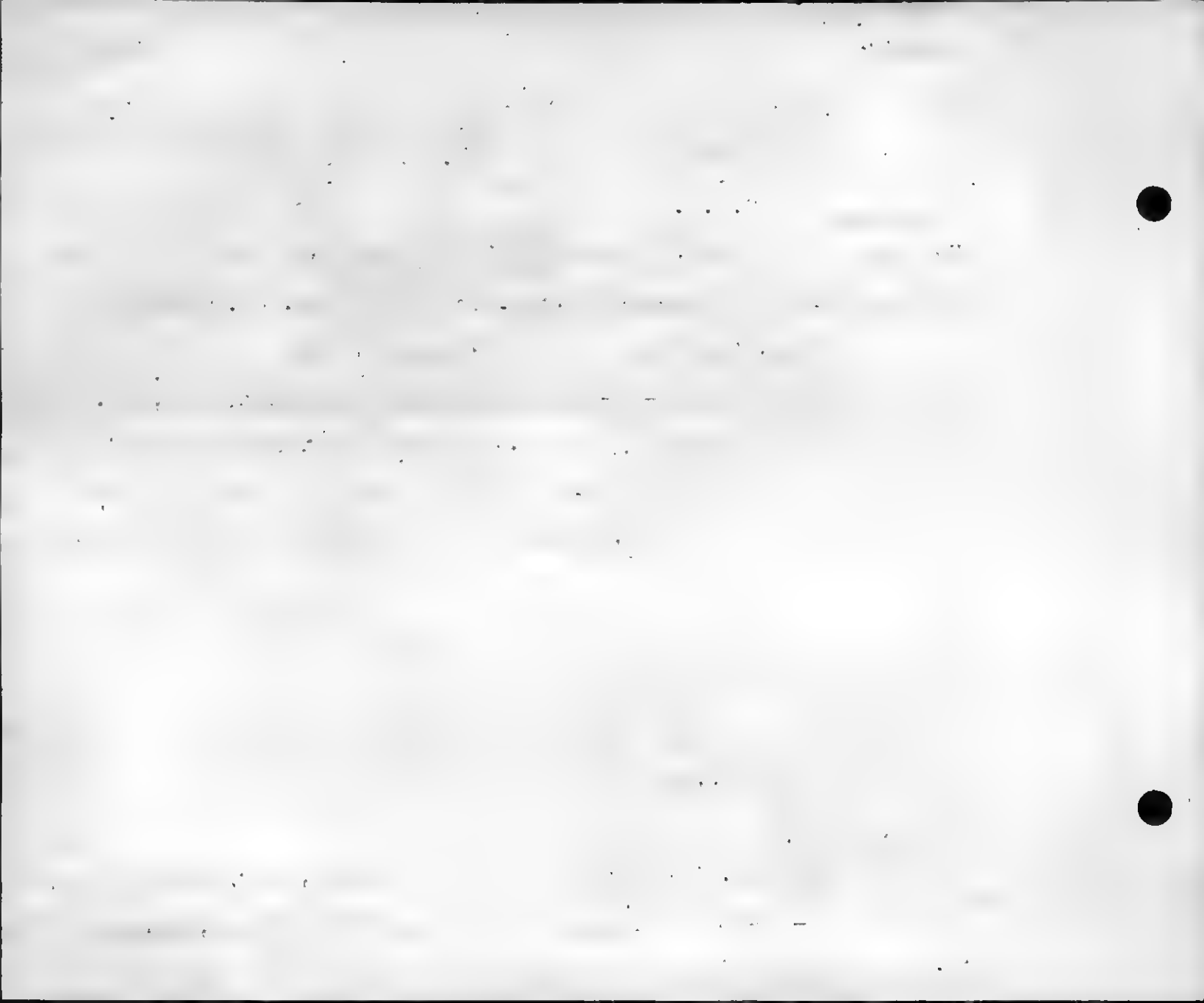


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|---|-------------------|--|--|---|--|---|----------------------------------|--|-----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b. HOUR | | | |
| Henry Shultie | | | | | | 1 Month 22 Day 1968 | | | M | | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | Dec. 8, 1881 | | | 86 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | U.S.A. | | | | Dorchester Md | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If home, give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Hurlock | | Belle Haven Nursing Home | | | | Retired Farmer | | | None | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | | |
| Maryland | | Caroline | | Greensboro | | | | No. Main Street | | | | |
| 14. FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | |
| Phillip Shultie | | | | No Record | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | | | | |
| No | | 217-30-8722 | | Amanda Shultie Greensboro, Md. | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident Thrombosis | | | | | | | | | | minutes | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis | | | | | | | | | | 25 yrs | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cerebral Disease | | | | | | | | | | 25 yrs | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner) | | 21b TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION | | Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/4/67, 19__, to 1/31/68, 19__, that (I) (we) last saw the deceased alive on 1/16, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | 22c. DATE SIGNED | | | | |
| Harold B. Plummer M.D. | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e ADDRESS | | | | | | | | |
| Harold B. Plummer | | | | Preston, Maryland | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 1-23-68 | | Greensboro | | | Greensboro, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | |
| J.E. Bouclair Greensboro, Md. | | | | | | JAN 25 1968 | | Charles Judge | | | | |

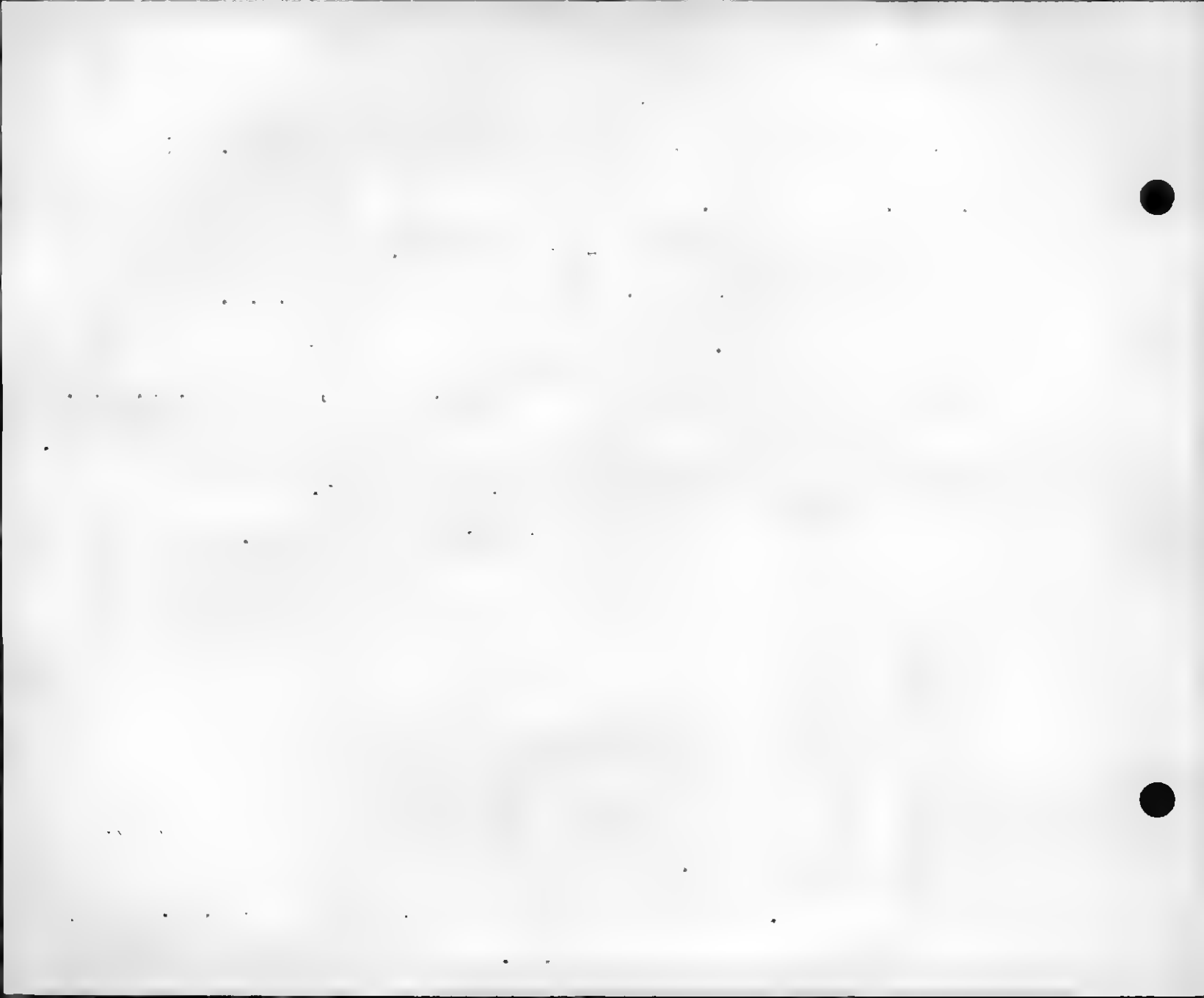


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--------|--|--|--|--|--|---|----------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | | 2b. HOUR |
| June | | | Lorraine | | | Simmons | | | 9 P M |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS DAYS | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Female | White | July 17, 1922 | 45 YRS | | | Month Jan. Day 12 Year 68 | | | M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md |
| Penna. | | U.S. | | | | Dorchester | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cambridge | | | Cambridge-Maryland Hosp. | | | Homemaker | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| Maryland | | | Dorchester | Cambridge | | R.F.D. # 1 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Raymond L. Shelly | | | Rebecca Payne | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | |
| No | | | | | Lucas C. Simmons, Cambridge, Md. R.D. 1 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Asphyxia | | | | | | | | | Few Min. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Condit ons, if only, which gave rise to immediate cause (a), stating the underlying cause | | | | | | | | | |
| (b) Obstruction bronchus, mucous. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Previous pneumonectomy other lung. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | |
| 002.1 Pulmonary tuberculosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | 1/14/68 | | | |
| John mace Jr. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Jan. 16, 1968 | | Green Lawn Cemetery | | Cambridge, Md. | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REG STRAR | | 25b. REG STRAR'S SIGNATURE | |
| Kenneth A. Thomas | | | Cambridge, Md. | | | JAN 18 1968 | | Charles Judge | |



FOR STATE
HEALTH DEPT.

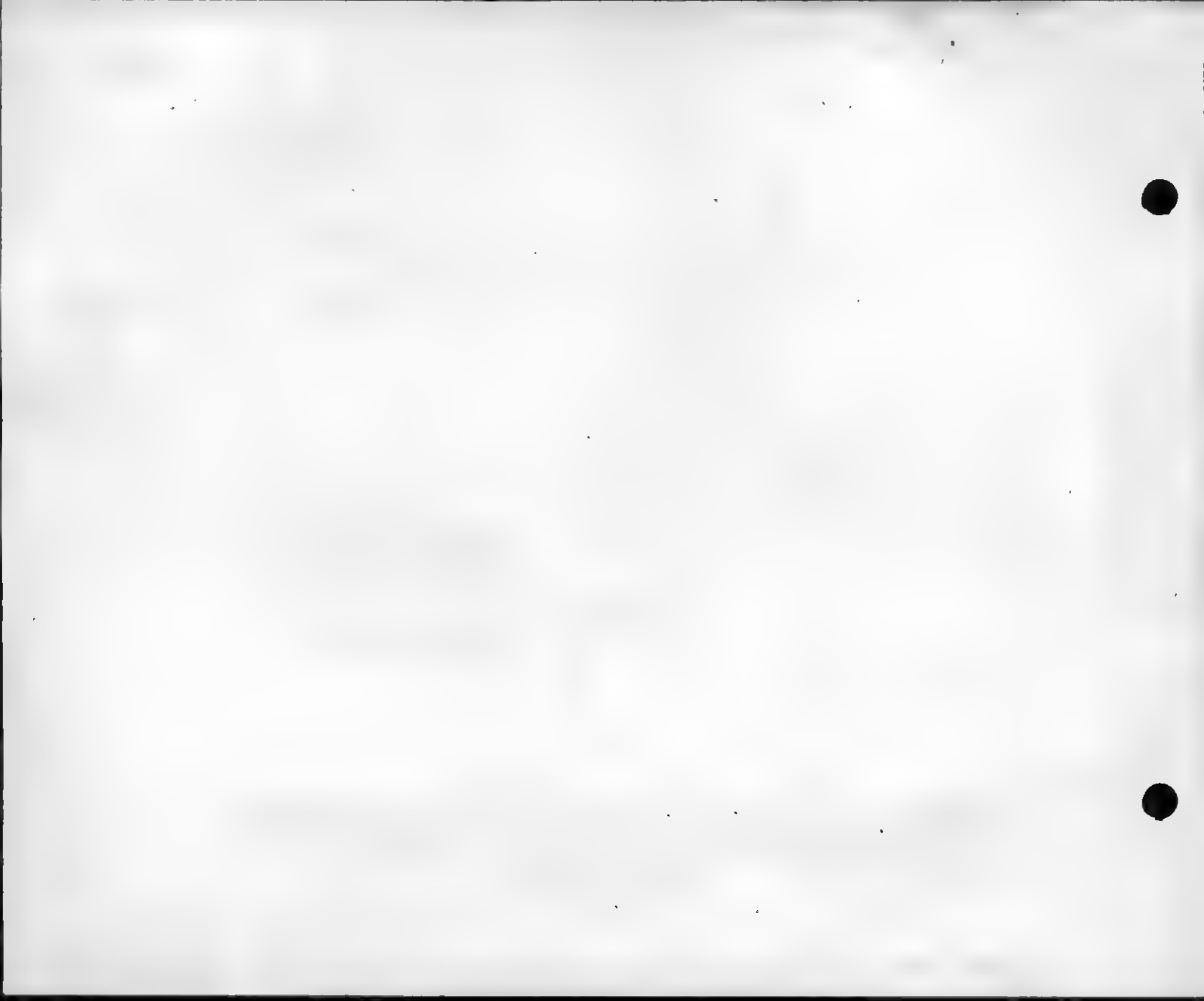
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1-25-63 mt 00860
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00859

| | | | | | | | | | | |
|---|-----------------|---|--|---|---|---|--|--|--|--|
| 1 DECEASED NAME
(Type or Print) | | | First | Middle | Last | 2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year
OF EST. DEATH MATED <input type="checkbox"/> JAN. 17 1968 | | | 2b HOUR
5:20 P | |
| ELsie | | | WASHINGTON | | | SMACK | | | | |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5 DATE OF BIRTH
9/2/98 | 6 AGE (in years
last birthday)
59 YRS | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c DATE PRONOUNCED DEAD
Month JAN. Day 17 Year 1968 | | |
| 7a BIRTHPLACE (State or foreign country)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
DORCHESTER Md. | | | | |
| 10 CITY OR TOWN OF DEATH
RURAL CAMBRIDGE | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
EASTERN SHORE STATE HOSPITAL | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.)
DRESSING FOWL | | 12b KIND OF BUSINESS OR INDUSTRY
Poultry | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
MD. | | | 13b COUNTY
WORCESTER | | 13c CITY OR TOWN
GIRDLETREE | 13d INS. OF CITY JAN 1967
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | |
| 14 FATHER'S NAME
SYDNEY SMACK | | | First | Middle | Last | 15. MOTHER'S M A D E N NAME
MARY GRIFFIN | | | First Middle Last | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | | 16b SOCIAL SECURITY NO
(If yes give war or dates of service)
NONE | | 17 INFORMANT
HOSPITAL RECORDS | | | | ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) ASPHYXIATION
DUE TO, OR AS A CONSEQUENCE OF
FOOD ASPIRATION
(b) FOOD ASPIRATION
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
INSTANT
INSTANT | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a DATE OF OPERATION
1/17/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
ASPIRATED FOOD | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. 5:20 P.M. 1/17 1968 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
ASPIRATED FOOD | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
HOSPITAL | | 21f LOCATION Street or R.F.D. No
CAMBRIDGE, MD. | | City or Town
DORCHESTER Co. | | County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
JO N. MACE, D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | 22b DATE SIGNED
1/17/68 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
Jan 20, 1968 | | 23c NAME OF CEMETERY OR CREMATORY
Whitcomb Mth. | | 23d LOCATION (City or Town) (County) (State)
Snow Hill, Md. | | | | |
| 24 FUNERAL DIRECTOR
Charles J. Jones, Snow H. Hl, Md. | | | | 25a. REC'D BY REG. STRAR
DATE JAN 22 1968 | | 25b REGISTRAR'S SIGNATURE
Charles J. Jones | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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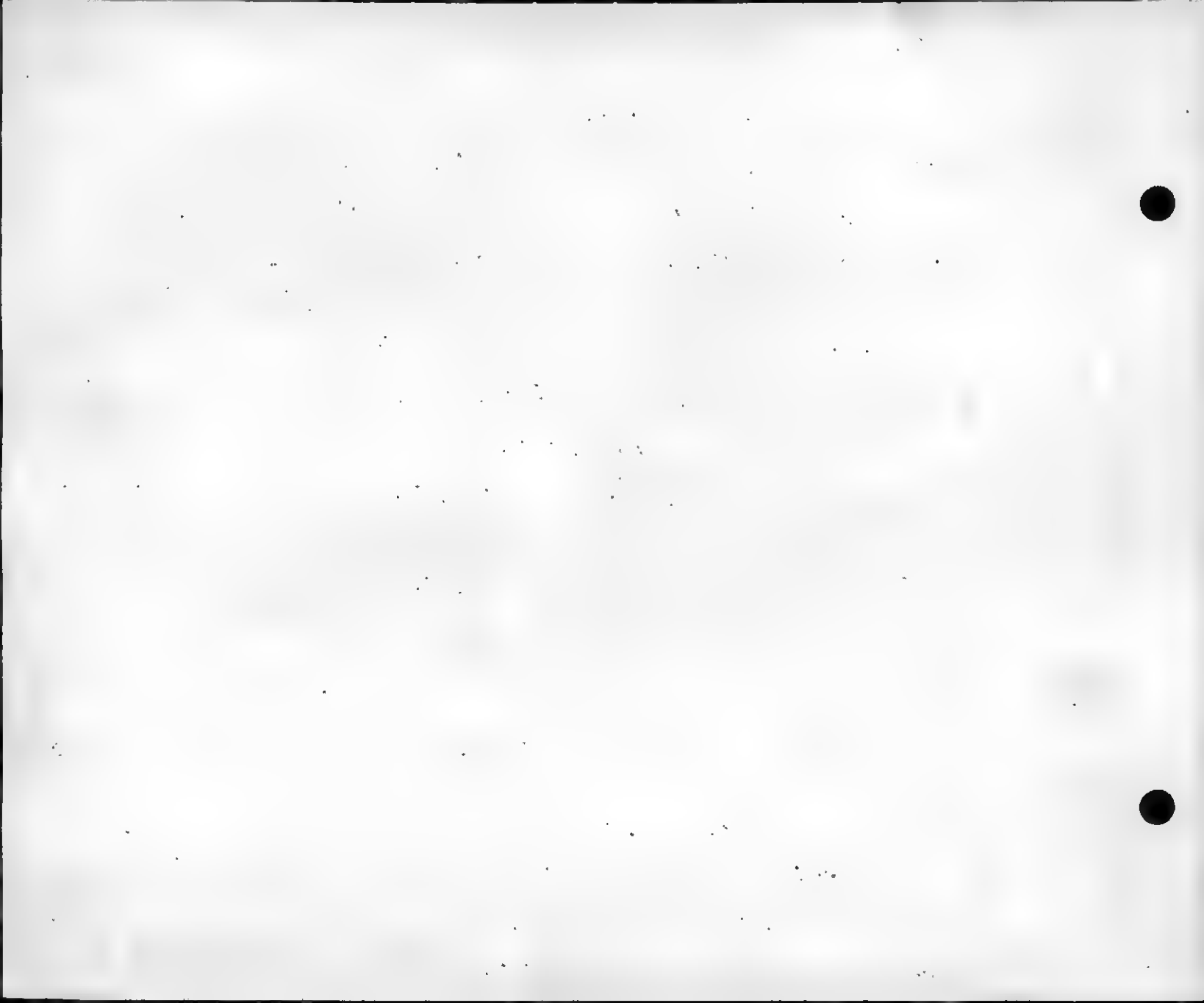
VR 100 (1)
304 REV. 11-68

06861

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00460

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| 1 DECEASED-NAME
(Type or print) First Middle Last
James Edward Stanley | | | 2a DATE OF DEATH
Month Day Year
1 15 68 | | | 2b. HOUR
M | |
| 3 SEX
male | | 4. RACE
Negro | | 5. DATE OF BIRTH
11/13/1886 | | 6 AGE (In years lost birthday)
82 YRS. | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md | |
| 10 CITY OR TOWN OF DEATH
Cambridge | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Eastern Shore State Hosp. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
School Sanitor | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b COUNTY
Talbot | | 13c CITY OR TOWN
Easton | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME First Middle Last
James Stanley | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Stanley | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
UNKNOWN | | 16b SOCIAL SECURITY NO.
NOT KNOWN | | 17 INFORMANT Address
Eastern Shore State Hosp. Cambridge, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) SENILE DEBILITY | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
GENERALIZED ARTERIOSCLEROSIS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 7-20-1967 to 1-15-1968, that (I) (we) last saw the deceased alive on 1-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward Lewis MD | | DEGREE
MD | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1-15-68 | |
| 22d PHYSICIAN'S NAME (Type)
EDWARD LEWIS, MD | | 22e ADDRESS
ESSH, CAMBRIDGE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
1/18/68 | | 23c NAME OF CEMETERY OR CREMATORY
Trappe Cem. | | 23d LOCATION (City or Town) (County) (State)
Trappe Md | |
| 24. FUNERAL DIRECTOR
George H. Doherty | | ADDRESS
Easton Md | | 25a REC'D BY REGISTRAR
JAN 18 1968 | | 25b REGISTRAR'S SIGNATURE
George H. Doherty | |



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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 00862 | | | | | | | | | |
| 00461 | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MIRIAM | | | TAYLOR | | | JAN 20 1968 | | 12:20 PM | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| F | | W | | SEPT 22, 1887 | | 88 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MD | | USA | | | | DOVERLESTER | | Md | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| HURLOCK | | | DOVERLESTER | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MD | | | ANNE ARUNDEL | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| WILLIAM D. TAYLOR | | | MARY CATHERINE HEGNUTT | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| | | | | | | MRS. GILBERT HEGNUTT DENTON | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac D-compensation | | | | | | | | | 1 wk |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | 10yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Hypertensive Arteriosclerosis | | | | | | | | | 10yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| Primary anemia ? Mid intestinal Obstruction | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home farm street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5/68, 19, to 1/20/68, 19, that (I) (we) last saw the deceased alive on 1/19/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | |
| 1/21/68 | | | | | | 1/21/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| CHARLES Y. MOORE M.D. | | | | | | DENTON | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | JAN 23, 1968 | | DENTON | | DENTON MD. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | |
| CHARLES Y. MOORE DENTON, MD. | | | | | | JAN 26 1968 | | [Signature] | |

MEDICAL CERTIFICATION



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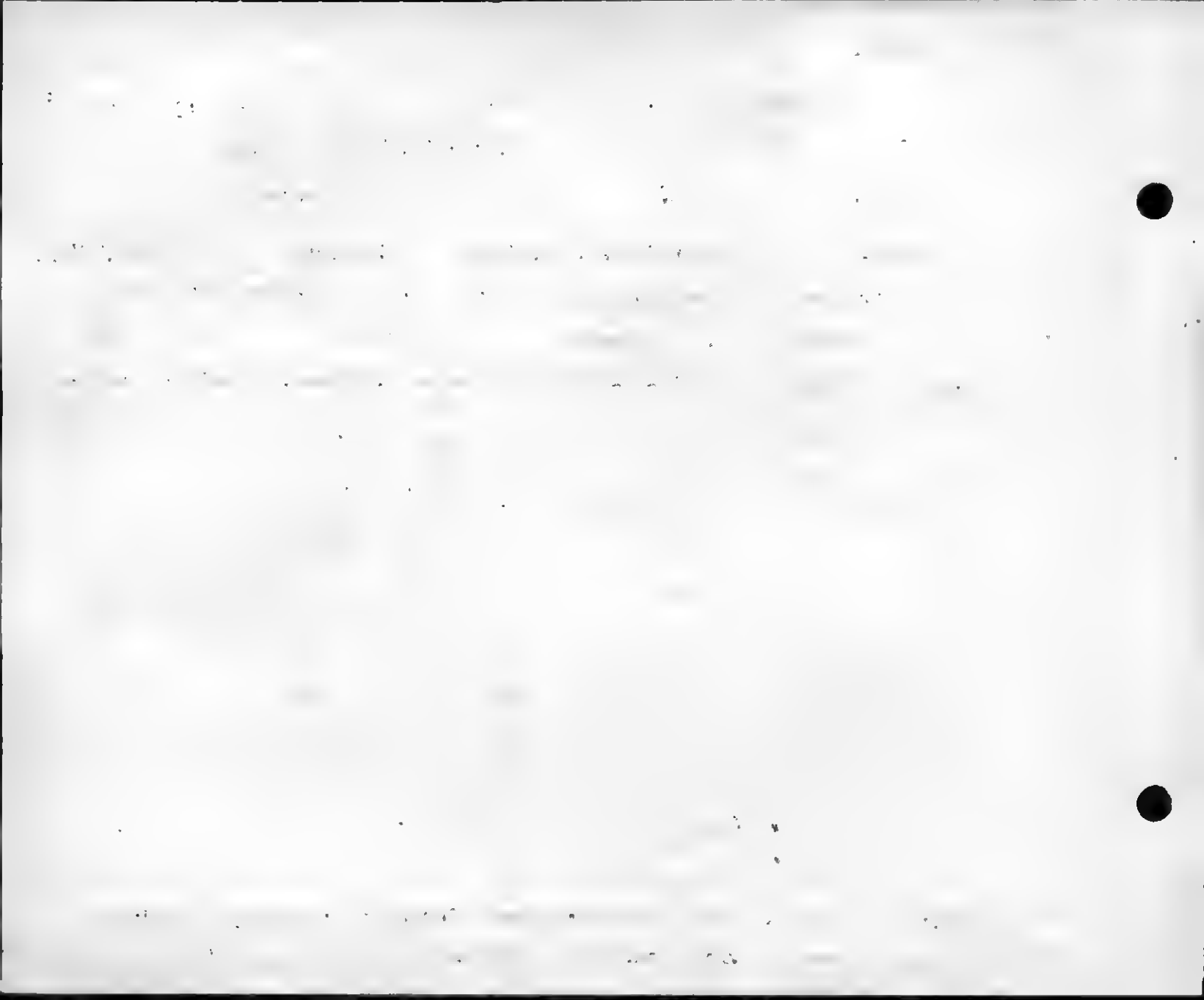
VR A 10
30M REK 1 AB

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00863

00862

| | | | | | | | |
|--|--|---|---------------------------------------|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) | | First
VERNON | Middle
F. | Last
THOMAS | 2a. DATE OF DEATH
Month Jan Day 10 Year 1968 | | 2b. HOUR
4:05 PM |
| 3 SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
April 30, 1887 | | 6 AGE (In years
first birthday)
80 YRS. | IF UNDER YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester | | Md | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Cambridge Md. Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Inspector | | 12b. KIND OF BUSINESS OR
INDUSTRY Tide. Fish. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE Maryland | | 13b. COUNTY Dorchester | 13c. CITY OR TOWN
Cambridge | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
212 Bay View Avenue | | |
| 14. FATHER'S NAME
First Thomas Middle J. Last Thomas | | 15. MOTHER'S MAIDEN NAME
First Sarah Middle ? Last Dail | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
Yes WW I | | 16b. SOCIAL SECURITY NO
216-30-6303 | | 17. INFORMANT
Address
Mrs. Vernon F. Thomas, Cambridge, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
456.0 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 days
1 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/2/68 , 19 68 , to 4/10/68 , 19 68 , that (I) (we) last saw the deceased alive on 4/10/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lawrence Maryann | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
4/12/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Lawrence Maryann | | | | 22e. ADDRESS
610 Race St
Cambridge, Md | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
Jan 12 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Christ Episcopal Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cambridge, Maryland | |
| 24. FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



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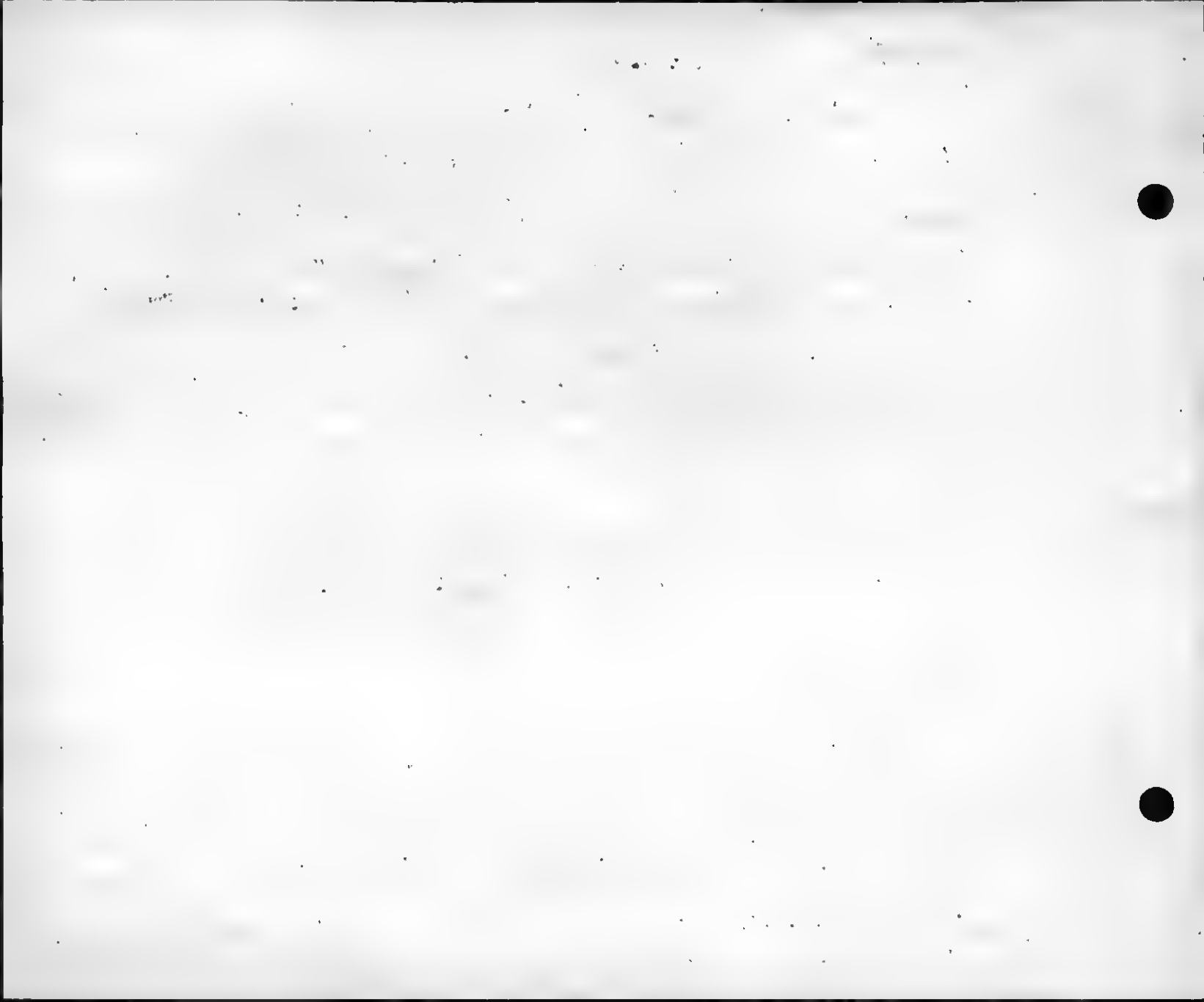
VR 10-68
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00863

| | | | | | |
|---|-------------------------|--|--|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
Della GRACE Tilghman | | | 2a. DATE OF DEATH Month Day Year
1 14 68 | | 2b. HOUR
11-4 M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
10-01-90 | | 6. AGE (In years last birthday)
77 YRS | 7. FUNDER 1 YEAR MONTHS DAYS
77 |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Dorchester | | 10. CITY OR TOWN OF DEATH
Cambridge | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Eastern Shore State Hosp | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | | 13a. CITY OR TOWN
Salisbury | |
| 13b. COUNTY
Wicomico | | 13c. STATE
Maryland | | 13d. STREET AND NUMBER
Merritt Mill Rd. | |
| 14. FATHER'S NAME First Middle Last
William H. Wright | | 15. MOTHER'S MAIDEN NAME First Middle Last
Harriett Jane Harvey | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
No | |
| 16b. SOCIAL SECURITY NO.
214-10-8197 D | | 17. INFORMANT
Mr. Robert Tilghman (Step-son) | | 18. ADDRESS
Eastern Shore State Hosp, Cambridge, Md. | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (b) 7 DAYS -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 470X
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CHRONIC GENERALIZED ARTERIOSCLEROSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (this hospital) attended the deceased from 9-19-1967 to 1-14-1968 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 1-14-1968 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward Lewis MD | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1-14-68 | |
| 22d. PHYSICIAN'S NAME (Type)
EDWARD LEWIS JR, MD | | 22e. ADDRESS
ESSH, CAMBRIDGE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 17, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Parsons Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Salisbury, Maryland | | 24. FUNERAL DIRECTOR
HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR
JAN 19 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

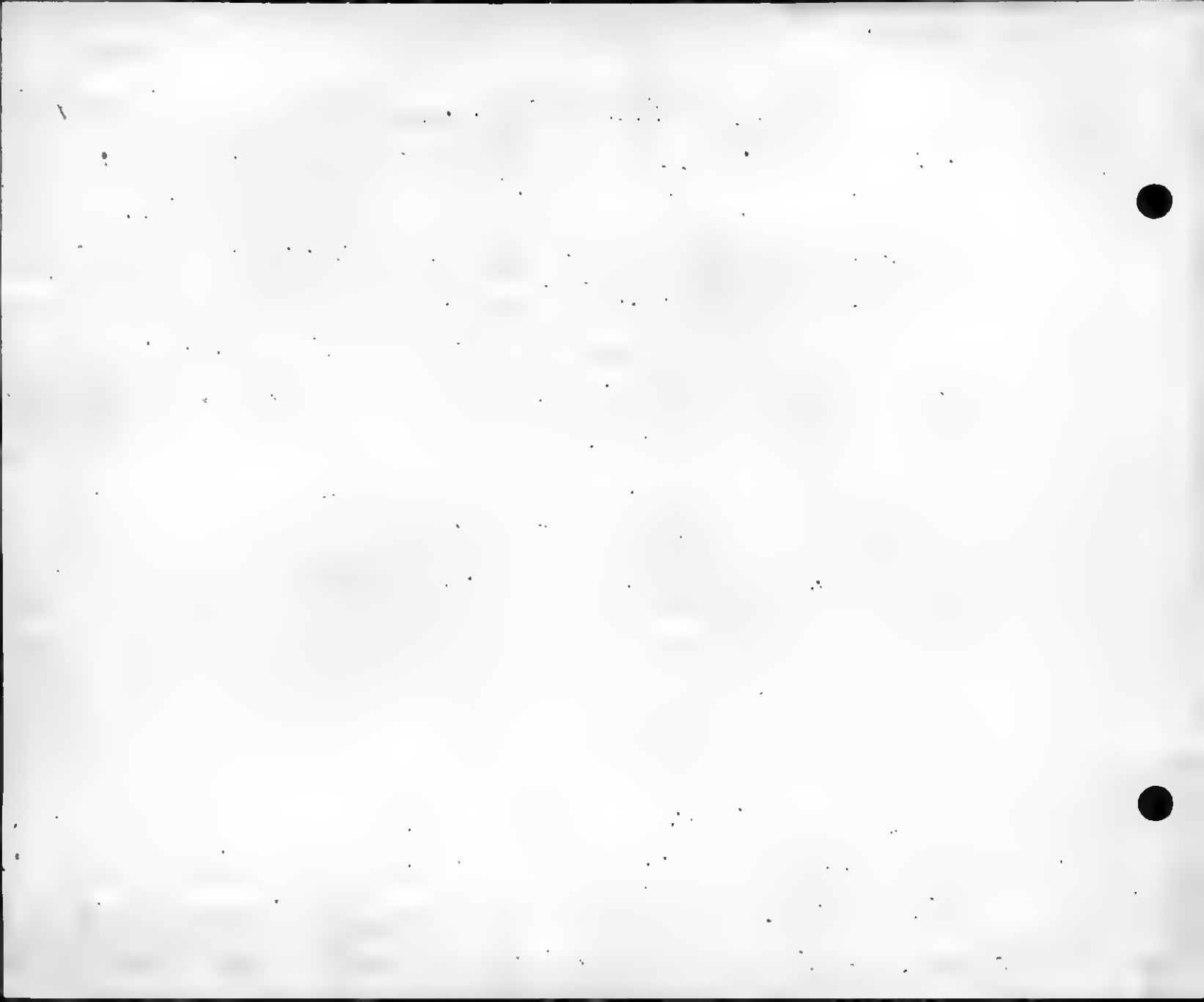


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VR 1-1-68
304A REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Richard Henry Tolliver | | | | | | 2a. DATE OF DEATH Month 1 Day 21 Year 68 | | | 2b. HOUR 9:15 AM | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
7-11-87 | | 6. AGE (In years last birthday)
80 YRS | | 7. UNDER 1 YEAR MONTHS 7 DAYS 21 | | 8. UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Eastern Shore State | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY
LUMBER | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Talbot | | | 13c. CITY OR TOWN
St. Michaels | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
— | |
| 14. FATHER'S NAME First Middle Last
Thomas Tolliver | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Harriet Thomas | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
No | | | | 16b. SOCIAL SECURITY NO.
215-20-0016A | | 17. INFORMANT Address
Susie Tolliver St. Michaels, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA
IX DUE TO, OR AS A CONSEQUENCE OF (b) PERITONSILLAR ABSCESS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) RENAL FAILURE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
5 DAY
1 WK | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
GENERALIZED SEVERE ARTERIOSCLEROSIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Sean M. Killoran MD | | | | | | 22c. DATE SIGNED
JAN 21, 1968 | | 22d. PHYSICIAN'S NAME (Type)
SEAN M. KILLORAN | | | |
| 22e. ADDRESS
7415 BLAIR RD, WASHINGTON DC | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposal
Burial | | 23b. DATE
JAN 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
THOMAS MEMORIAL | | 23d. LOCATION (City or Town) (County) (State)
ST. MICHAELS, MD. | | | | | |
| 24. FUNERAL DIRECTOR
Lawson E Leonard, St. Michaels, Md | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 23 1968 | | 25b. REGISTRAR'S SIGNATURE
Merrill J. Judge | | | |



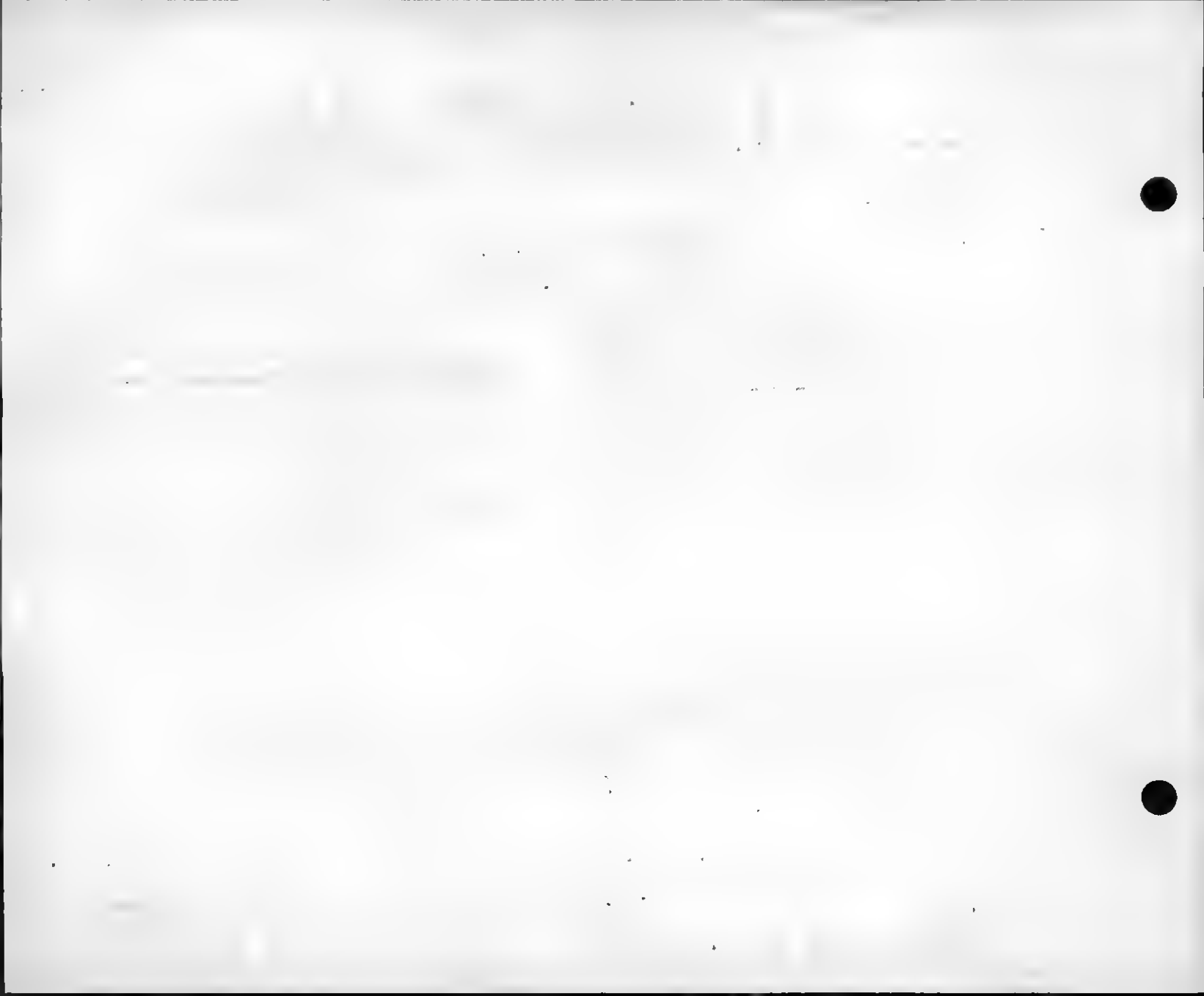
FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

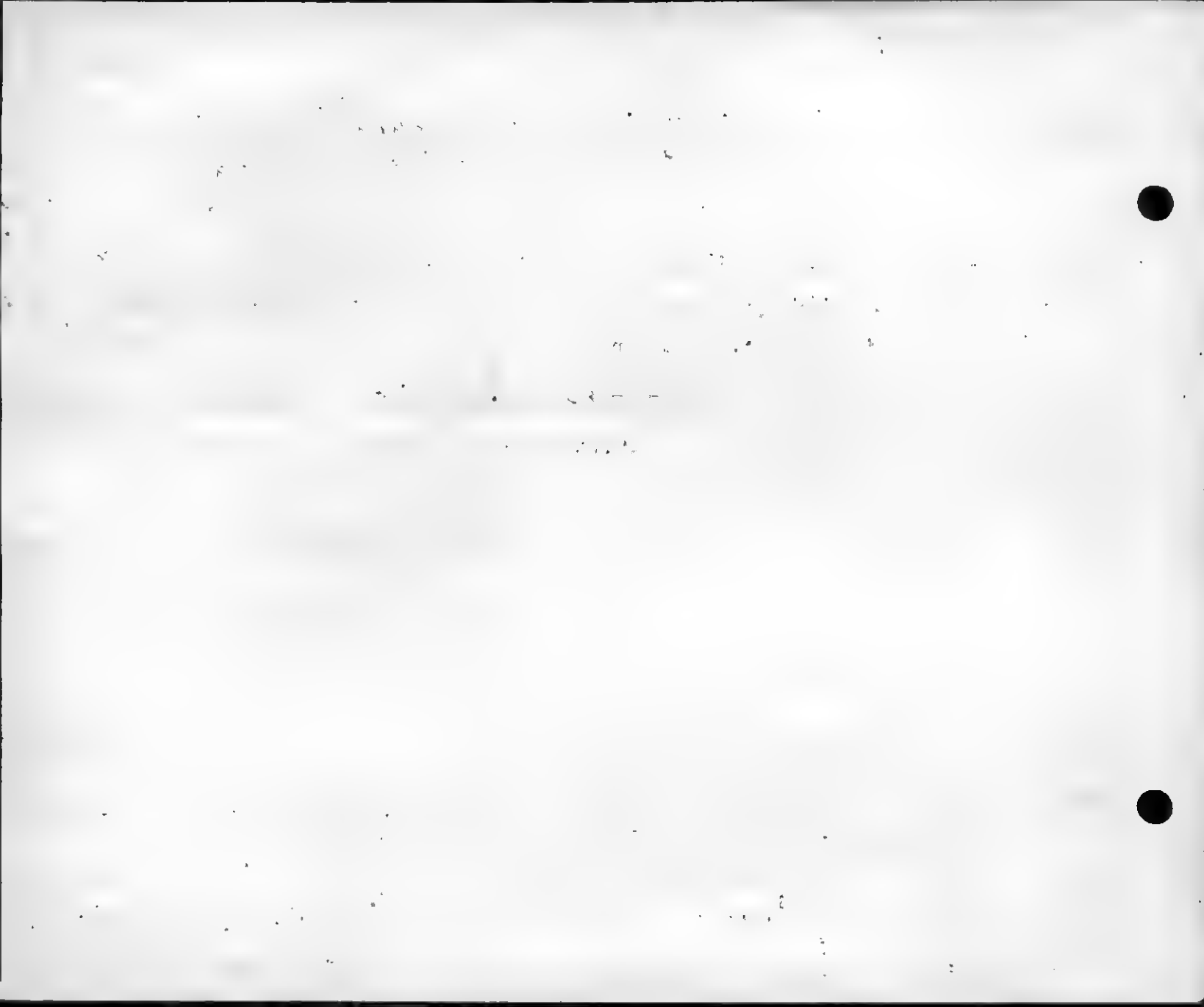
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|------------------------|--|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | First
MINNIE | | Middle
G. | | Last
TRAVERS | | 2a DATE KNOWN OF DEATH
Month Jan Day 7 Year 1968 | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
Mar. 28, 1904 | 6 AGE (In years last birthday)
63 1/2 YRS. | IF UNDER 1 YEAR
MONTHS
6 DAYS
32 | IF UNDER 24 HRS
HOURS
12 MIN
45 | 2c DATE PRONOUNCED DEAD
Month Jan Day 7 Year 1968 | | 2b HOUR
7:45 AM | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Dorchester | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
DOA Cambridge Maryland Hos | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Household | | 12b KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b COUNTY
Dor | | 13c CITY OR TOWN
Cambridge | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
714 Hughlett St. | |
| 14. FATHER'S NAME
First Frank Middle ? Last Travers | | 15 MOTHER'S MAIDEN NAME
First Sarah Middle ? Last Meekins | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b SOCIAL SECURITY NO
(If yes give war or dates of service)
unk | | 17 INFORMANT
Miss Shirley Travers, Cambridge, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
4501
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Instant | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b TIME OF INJURY Month Day, Year
HOUR A.M. P.M.
19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
 | | EXAMINER'S NAME (Type)
John Mace Jr. M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | ADDRESS (Street, city, town, or county)
Cambridge, Md. | | 22b DATE SIGNED
1/8/68 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan 9 1968 | | 23c NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park | | 23d LOCATION (City or Town) (County) (State)
Cambridge, Maryland | | | |
| 24 FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | | | ADDRESS
Cambridge, Maryland | | 25a REC'D BY REGISTRAR
JAN 11 1968 | | 25b REGISTRAR'S SIGNATURE
 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 00866 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Herman D. Tyler | | | | | | Jan. Month 27 Day 19 Year 68 | | 4:35 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | 9/14/1886 | | 25 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Dorchester | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cambridge | | | Eastern Shore State Hosp | | | waterman | | Seafood | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | | Somerset | | | Tylerton, Md. | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Edward P. Tyler | | | Maggie Bradshaw | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | Address | |
| | | | 218-16-9383 | | | Eastern Shore State Hosp. | | Cambridge Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>
<u>tox</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>493x</u> | | | | | | | | | 1 WK |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>GENERALIZED ARTERIOSCLEROSIS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 26, 1968</u> , to <u>JAN 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>JAN 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | |
| Sean M Killoran MD | | | | | | JAN 27, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| SEAN M KILLORAN | | | | | | 7415 BLAIR RD, WASHINGTON, D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/30/68 | | Tylerton Cemetery | | Tylerton, Md. Somerset | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Levin B. Wilson - Princess Anne, Md. | | | | | | DATE FEB 2 1968 | | [Signature] | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

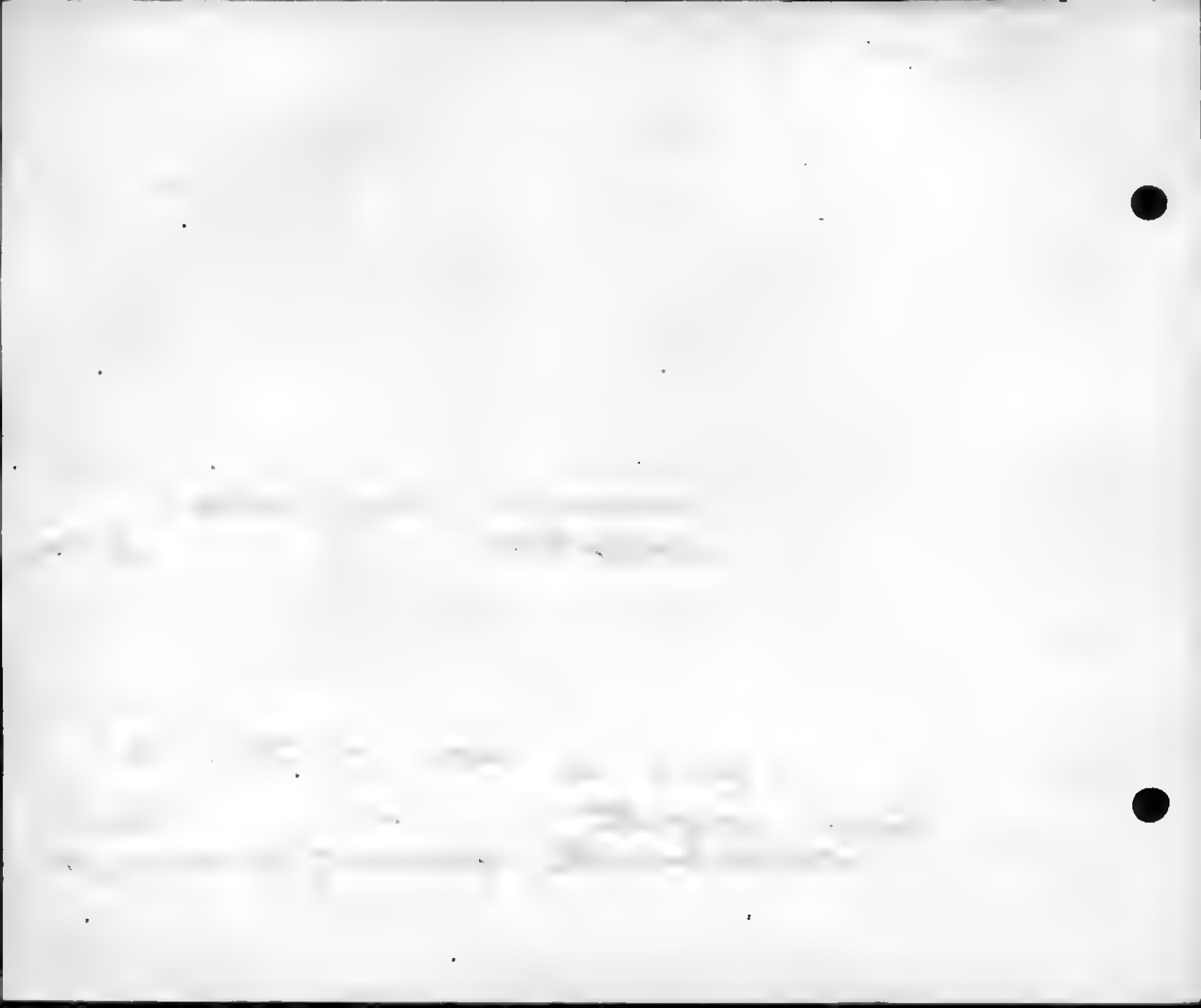
00867

00868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

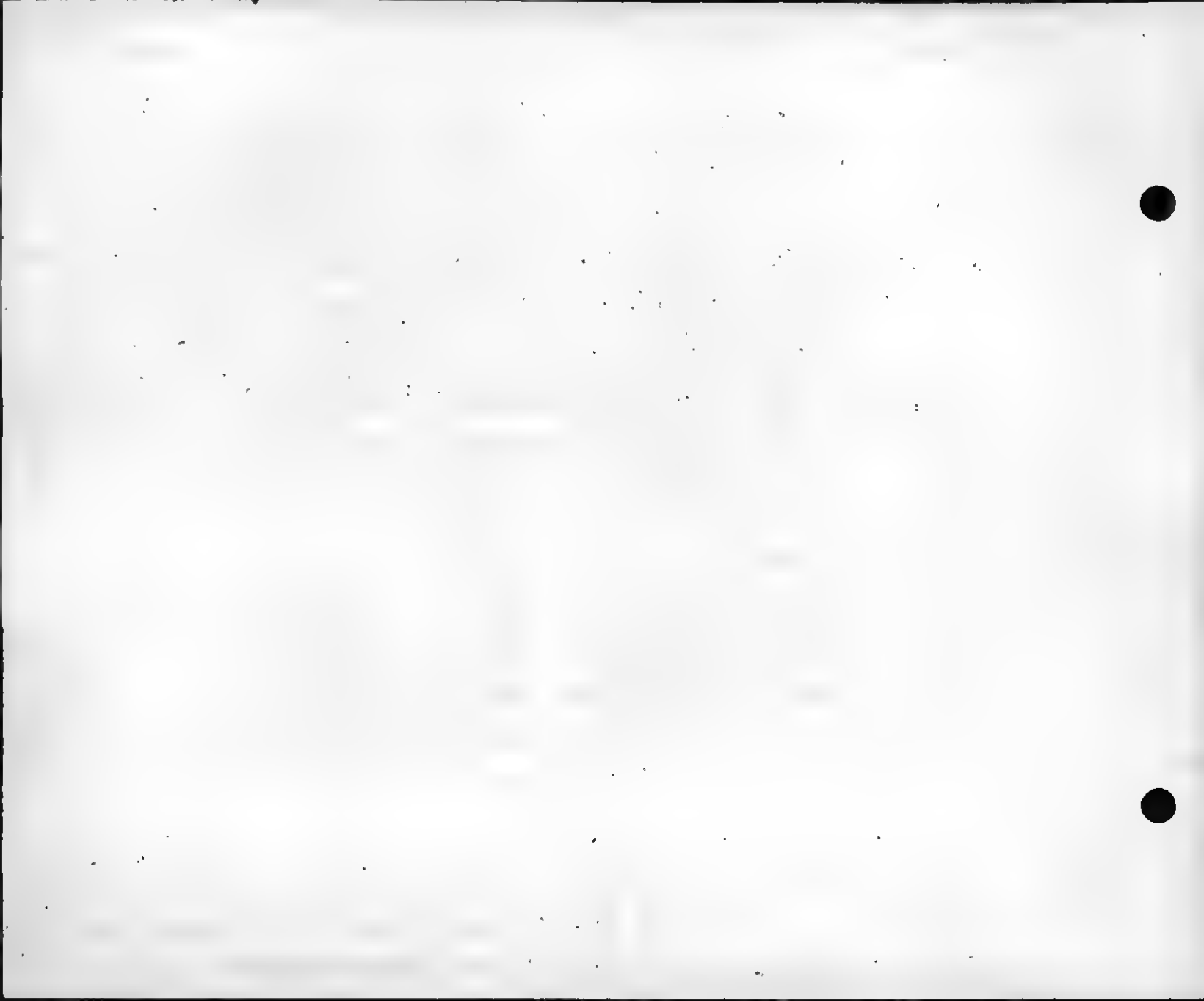
| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Dorchester
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cambridge | | c. LENGTH OF STAY IN 1b
3 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Cambridge-Maryland Hospital | | d. STREET ADDRESS
215 Somerset Ave., | |
| 3. NAME OF DECEASED (Type or print)
First Cecelia Middle Tolley Last Vickers | | 4. DATE OF DEATH
Month January Day 9 Year 1968 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 13, 1916 |
| 9. AGE (In years last birthday)
51 yrs | | 10. IF UNDER 1 YEAR
Months 2 Days 1 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sears, Mail Order Dept. | | 10b. KIND OF BUSINESS OR INDUSTRY
Fishing Creek | |
| 11. BIRTHPLACE (County & State or foreign country)
U.S. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Andrew Tolley | | 14. MOTHER'S MAIDEN NAME
Flora Booze | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
214-03-7291 | |
| 17. INFORMANT
Bradford A. Vickers, Jr., Cambridge, Md. | | Address 215 Somerset Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung with
DUE TO metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b)
(c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
2 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 1967 to Jan 9, 1968 , that (I) (we) last saw the deceased alive on Jan 9, 1968 , and that death occurred at 00:00 from causes and on the date stated above | | | |
| 22a. SIGNATURE
Lewis M. Burdette M.D. | | 22b. DATE SIGNED
10 Jan 68 | |
| 22c. PHYSICIAN'S NAME (Type)
Lewis M. Burdette | | 22d. ADDRESS
4 Aurora St., Cambridge, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 23b. DATE THEREOF
Jan. 11, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park, Cambridge, Md. | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR
Kenneth A. Thomas | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE JAN 15 1968 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>00869</div> <div>00868</div> | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|----------------------------|
| 1. DECEASED-NAME (Type or print) Harry Welch | | | | | | 2a. DATE OF DEATH 1 Month 7 Day 68 Year | | | 2b. HOUR M | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH 12-5-90 | | | 6. AGE (In years last birthday) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Dorchester Md | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge, MD. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT | | | 12b. KIND OF BUSINESS OR INDUSTRY GENERAL | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland | | | 13b. COUNTY Queen Anne's | | | 13c. CITY OR TOWN Centreville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER XX | |
| 14. FATHER'S NAME First Middle Last George Welch | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Kena Briscoe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 215-38-1355 | | 17. INFORMANT HARRY WELCH - CENTREVILLE MD. Address | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 486X CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) 493X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 HRS.
2 Days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
GENERALIZED ARTERIO SCLEROSIS. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building etc) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 6 , 19 68 to JAN 7 , 19 68 , that (I) (we) last saw the deceased alive on JAN 7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Sean M. Killoran DEGREE M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED JAN 7, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN | | | | | | 22e. ADDRESS 7415 BLAIR RD WASHINGTON D.C. | | | | | |
| 23a. BURIAL, CREMATION BURIAL | | 23b. DATE JAN. 10 | | 23c. NAME OF CEMETERY OR CREMATORY CHESTERFIELD | | | 23d. LOCATION (City or Town) (County) (State) CENTREVILLE MD. | | | | |
| 24. FUNERAL DIRECTOR Edgar L. Harris Church Hill, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR JAN 11 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Jones | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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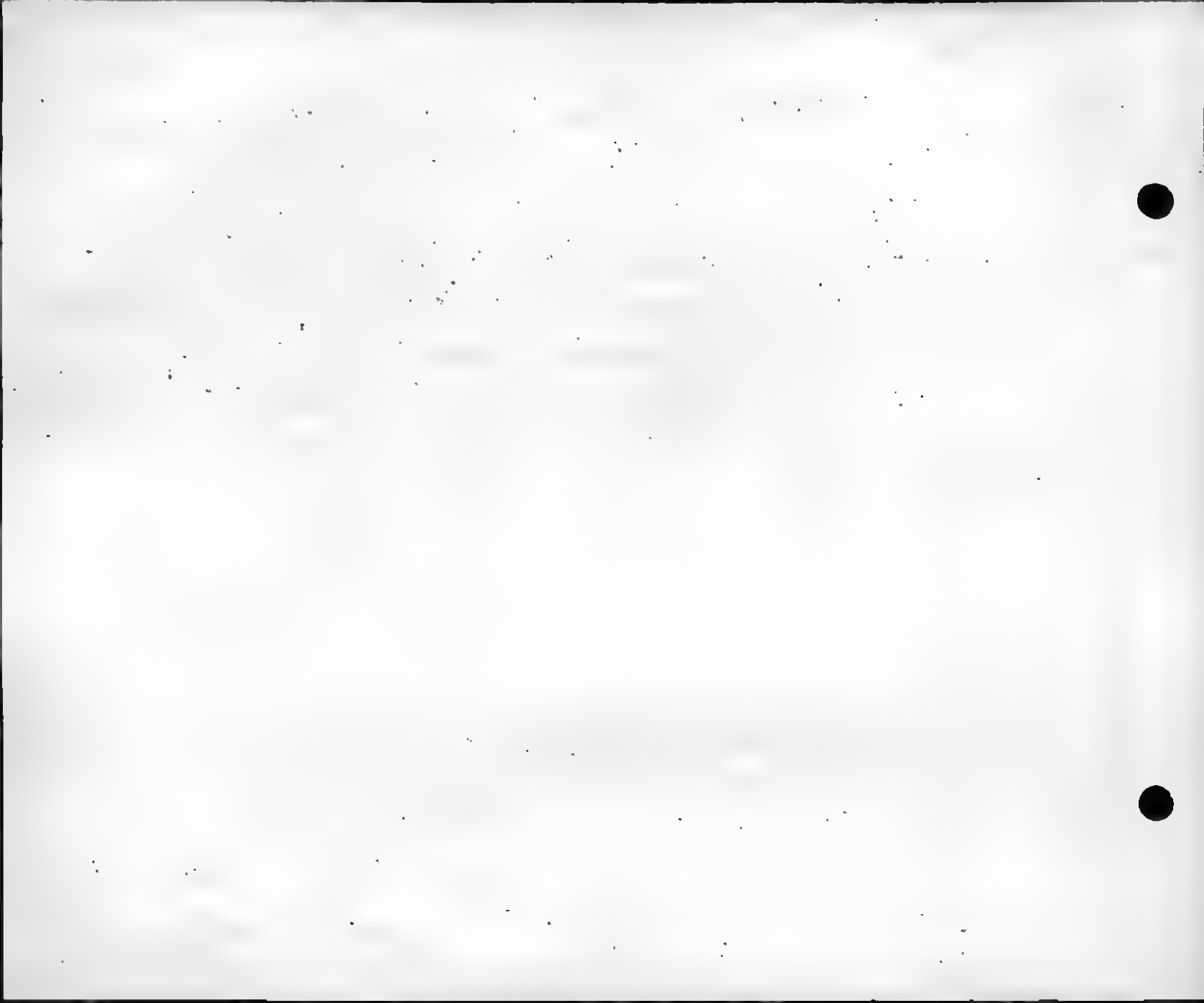
00870

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00869

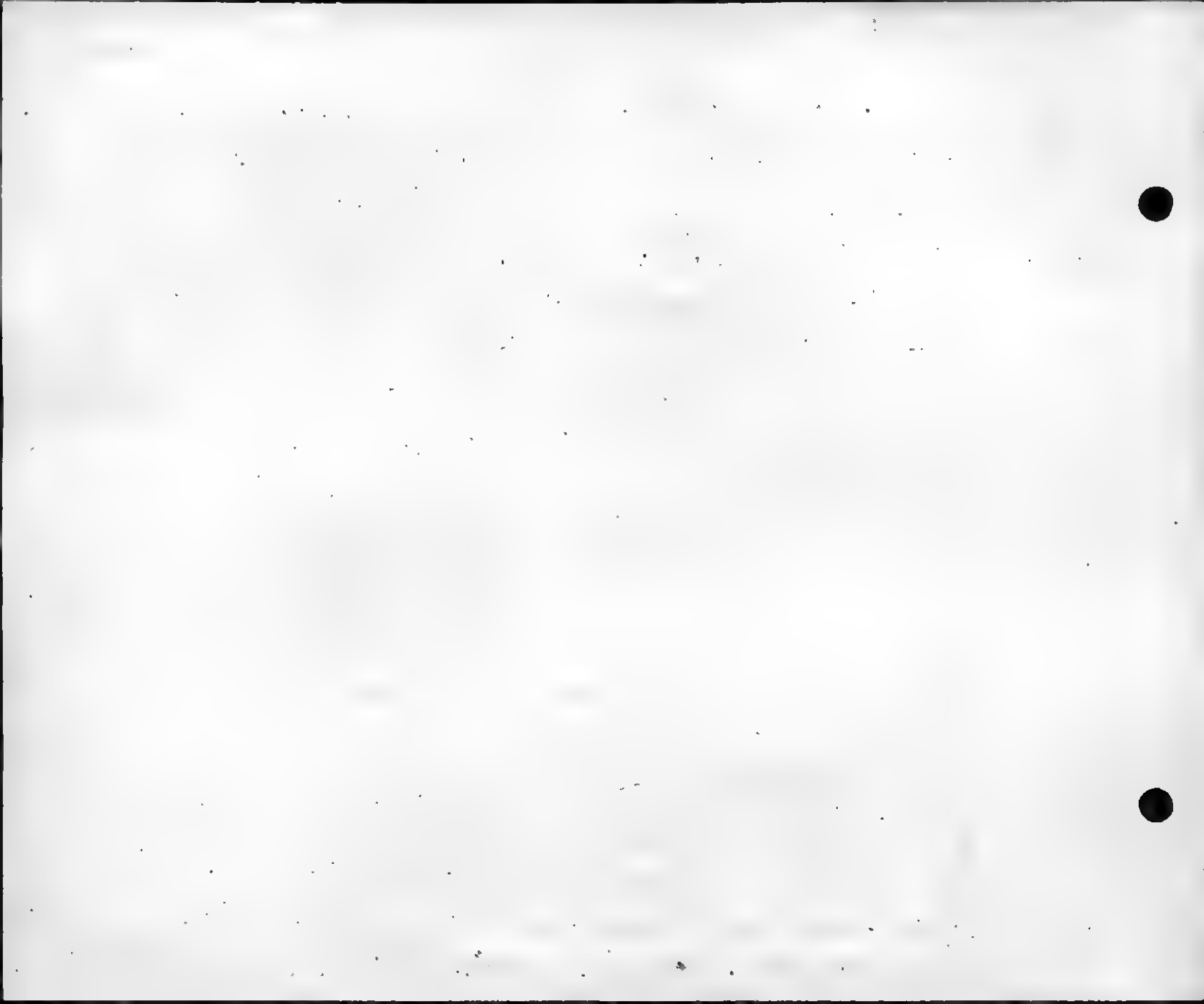
| | | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) MARY VELMA WELCH | | | 2a. DATE OF DEATH
Month January Day 12 Year 1968 | | | 2b. HOUR
4:45 PM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
9-02-90 | | 6. AGE (In years lost birthday)
77 YRS. | | IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Eastern Shore State Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
xx | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE
md. | | | 13b. COUNTY
Queen Anne's | | | 13c. CITY OR TOWN
Centreville | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
Samuel Sowell | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Wilhelmina Starkey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO
215-38-1355-B | | | 17. INFORMANT Address
Records-State Hosp-Cambridge | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Ischemic heart disease
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
471 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-4 , 19 68 , to 1-12 , 19 68 , that (I) (we) last saw the deceased alive on 1-12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Reproductive, M.D. | | | | | | DEGREE
ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED
1-12-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS
CAMBRIDGE, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
JAN. 15 | | 23c. NAME OF CEMETERY OR CREMATORY
CHASTERFIELD | | | 23d. LOCATION (City or Town) (County) (State)
CENTREVILLE MD. | | |
| 24. FUNERAL DIRECTOR
Edgar L. Harris | | | | | | ADDRESS
Church Hill, Md. | | | 25a. BY REGISTRATION
JAN 18 1968 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
William J. Jones | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

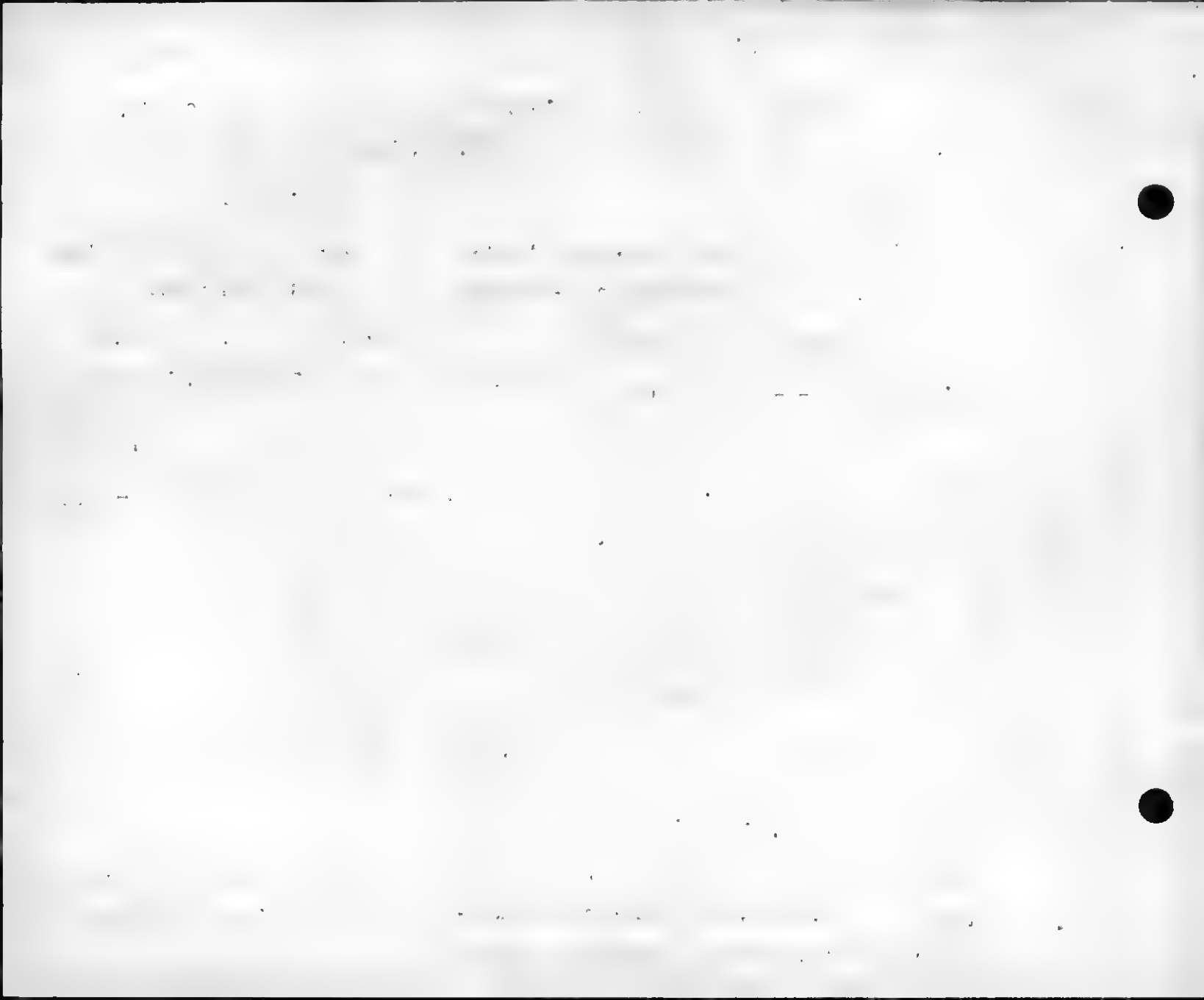
| <div>36871</div> <div> <div>MD</div> <div> <div>00870</div> <div>00870</div> </div> </div> | | | | | | | | | | | | |
|--|--|--|--|--|--|---|---|--|-----------------------------------|-------|-------------------------------|--|
| 1 DECEASED-NAME (Type or print) First Middle Last
LILLIAN FLORENCE WHEAT | | | | | | 2a DATE OF DEATH Month Day Year
JANUARY 23, 1968 | | | 2b. HOUR
9 A.M. | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH
7/17/95 | | | 6 AGE (In years last birthday)
72 YRS. | | 7 UNDER 1 YEAR
MONTHS DAYS | | 8 UNDER 24 HRS.
HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
DORCHESTER | | | Md | | | |
| 10 CITY OR TOWN OF DEATH
RURAL CAMBRIDGE | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
EASTERN SHORE STATE HOSP. | | | | 12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)
NONE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MO. | | 13b. COUNTY KENT | | 13c CITY OR TOWN MILLINGTON | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER X X | | | | |
| 14 FATHER'S NAME First Middle Last
WALLACE WHEAT | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
GERTRUDE 3 | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16b SOCIAL SECURITY NO.
217-54-5367 | | 17 INFORMANT Address
HOSPITAL RECORDS | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
455X DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 days | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/31, 1967, to 1/23, 1968, that (I) (we) last saw the deceased alive on 1/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Edgar Lane</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/23/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e ADDRESS CAMBRIDGE, MARYLAND | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE JAN. 27 | | 23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel | | 23d. LOCATION (City or Town) (County) (State) Rock Hall Kent Md. | | | | | | |
| 24. FUNERAL DIRECTOR <u>Edgar Lane Church Hill Md.</u> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
HOWARD | | | Middle
T. | | | Last
WHEATLEY | | | 2a. DATE OF DEATH
Month Jan. Day 22 Year 1968 | | | 2b. HOUR
M | | |
| 3 SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
Oct. 29, 1908 | | | 6. AGE (n years last birthday)
59 YRS | | | 7. UNDER 1 YEAR
MONTHS DAYS | | | 8. UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Dorchester | | | 9d. M.D. | | | | | |
| 10. CITY OR TOWN OF DEATH
Hurlock | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Belle Haven Nursing Hm. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
None | | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE Md | | | 13b. COUNTY Dorchester | | | 13c. CITY OR TOWN
Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
431 Race Street | | | | | |
| 14. FATHER'S NAME
First Jabez Middle ? Last Wheatley | | | 15. MOTHER'S MAIDEN NAME
First Lucy Middle ? Last Mills | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO
unk | | | 17. INFORMANT
Mrs. Bertie Cannon, Cambridge, Maryland | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) I fluenza ? Type
470X
DUE TO, OR AS A CONSEQUENCE OF
(b) Debility with congestive heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) Low grade Moron | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
63 mos
life | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/9/62 , 19 62 , to 1/22/68 , 19 68 , that (I) (we) last saw the deceased alive on 1/22/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Harold B. Plummer | | | | | | | | | | | | 22c. DATE SIGNED
1/24/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Harold B. Plummer M.D. | | | | | | | | | | | | 22e. ADDRESS
P. Box #153 Preston Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Jan 25, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Park | | | 23d. LOCATION (City or Town) (County) (State)
Cambridge, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR
LeCompte Funeral Service, Cambridge, Maryland | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 26 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

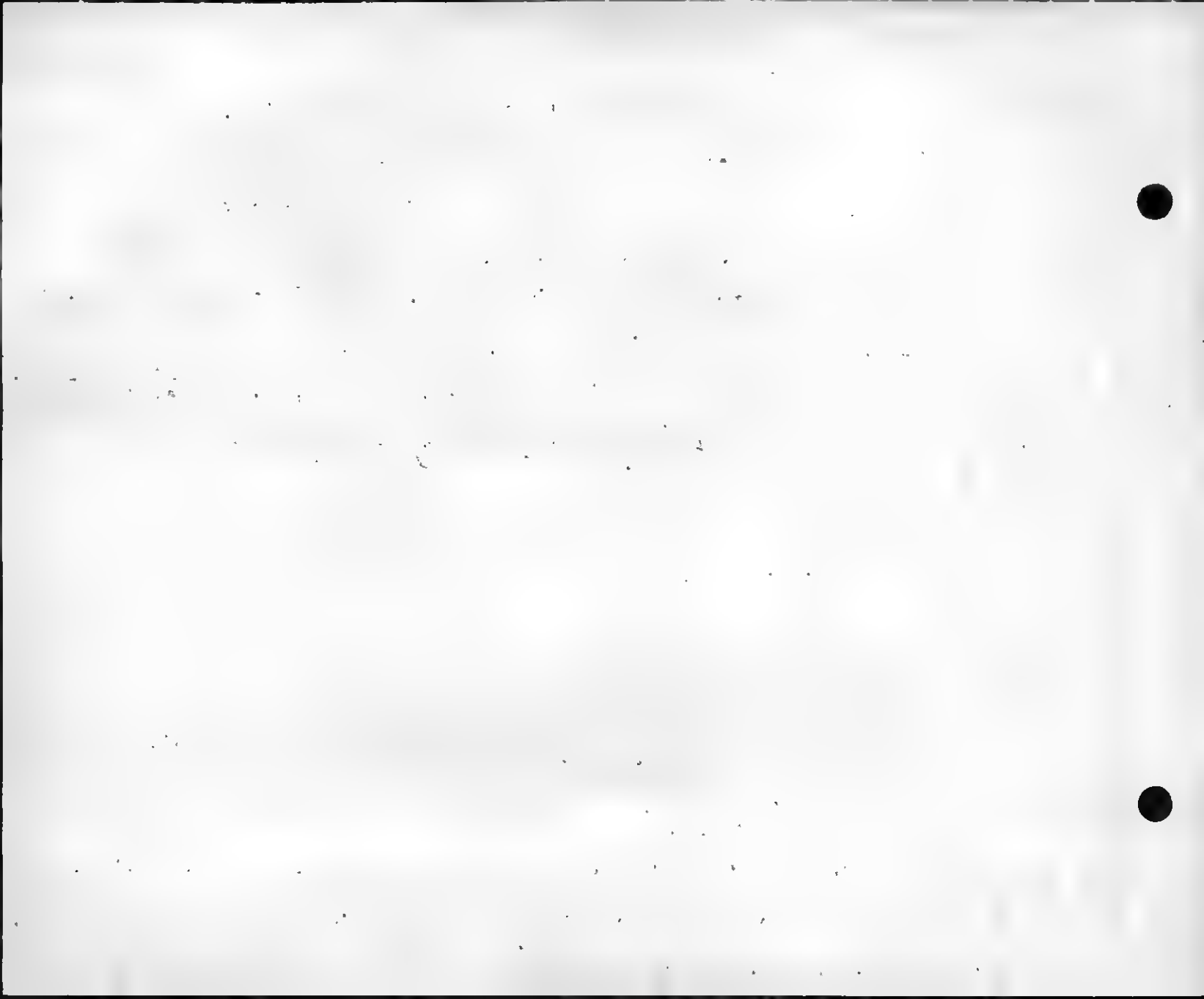


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Annie Elizabeth Wilkins | | | | | 2a. DATE OF DEATH
Month Day Year
Jan. 26, 1968 | | | 2b. HOUR
2 A M | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
4/13/1893 | | 6. AGE (In years last birthday)
74 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Dorchester | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Dorchester Md | | | |
| 10. CITY OR TOWN OF DEATH
Cambridge | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Cambridge Maryland | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Dorchester | | 13c. CITY OR TOWN
Cambridge | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
728 Washington Street | |
| 14. FATHER'S NAME First Middle Last
Samuel Wilkins | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah Clash | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
214-07-7539A | | 17. INFORMANT
Address Samuel Wilkins, Jr. 728 Washington St. Cambridge, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of endometrium</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Diabetes mellitus</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-20-1967</u> , to <u>1-26-1968</u> , that (I) (we) last saw the deceased alive on <u>1-26-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22c. DATE SIGNED
1/27/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. J. Edwin Fassett | | | | 22e. ADDRESS
Cambridge, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Bethel | | 23d. LOCATION (City or Town) (County) (State)
Cambridge Dorchester Md. | | | |
| 24. FUNERAL DIRECTOR
Barbara L. Dashiell | | | | 42b. ADDRESS
42b. Address
Easton, Maryland | | 25a. REC'D BY REGISTRAR
DATE JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

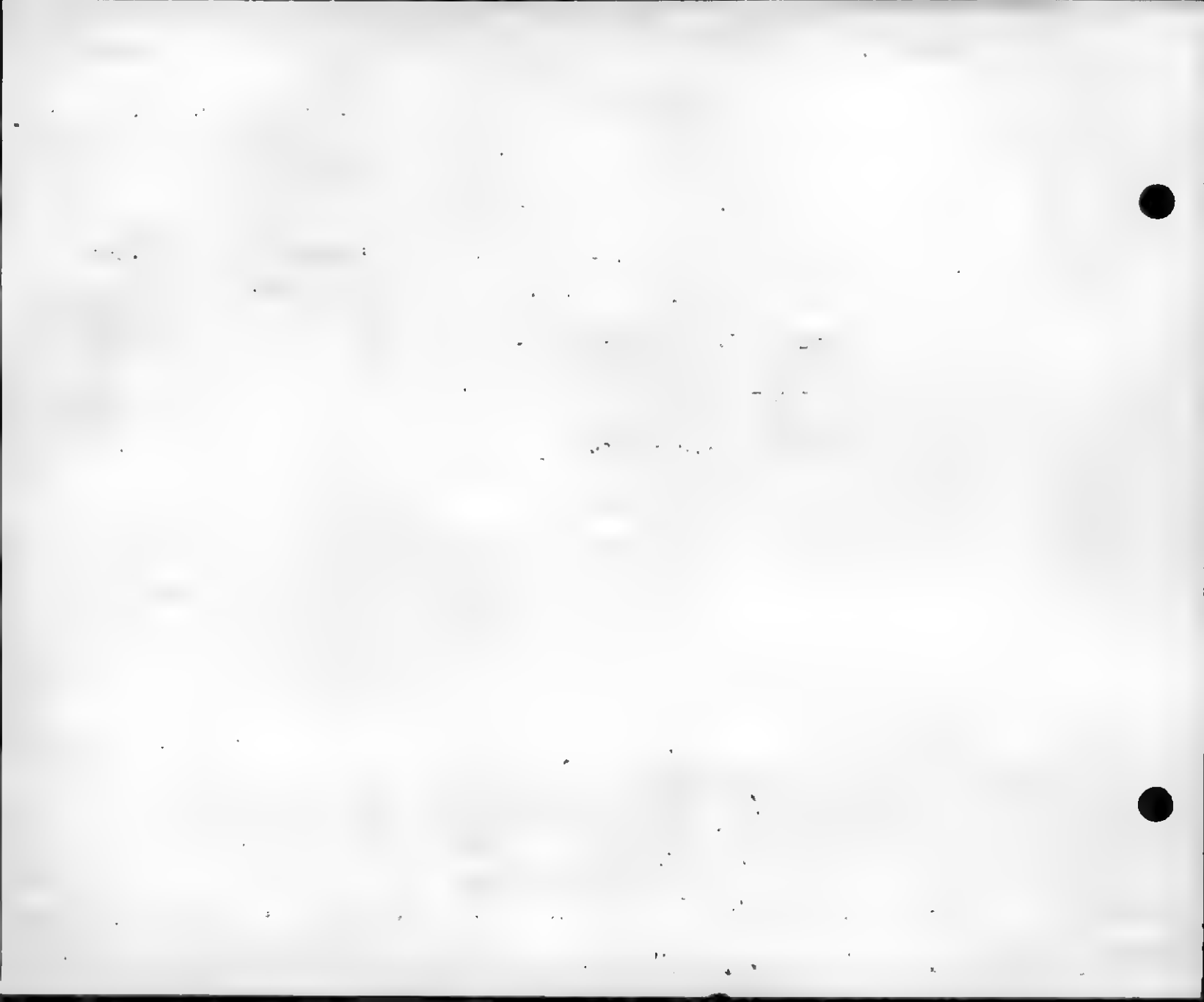


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VA 11-14
30M REV 1/68

| <div style="display: flex; justify-content: space-between;"> 00874 MARYLAND STATE DEPARTMENT OF HEALTH 00873 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) LULA | | | First ADAMS | | | Middle W'NGATE | | | Last | | | 2a. DATE OF DEATH
Month JANUARY Day 15 Year 1968 | | | 2b. HOUR
11:40M | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
2/6/95 | | | 6. AGE (In years last birthday)
72 YRS. | | | IF UNDER 1 YEAR
MONTHS 72 DAYS 72 | | | IF UNDER 1 YEAR
HOURS 72 MIN 72 | | |
| 7a. BIRTHPLACE (State or foreign country)
MD. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
DORCHESTER Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
RURAL CAMBRIDGE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
EASTERN SHORE STATE HOSPITAL | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
MD. | | | 13b. COUNTY
DOR. | | | 13c. CITY OR TOWN
WINGATE | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
None | | | | | |
| 14. FATHER'S NAME
First Edward Middle J. Last Adams | | | 15. MOTHER'S MAIDEN NAME
First Mary Middle ? Last Windsor | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
unk | | | 17. INFORMANT
Address
HOSPITAL RECORDS | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.
485x IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/21 , 19 66 , to 1/15 , 19 68 , that (I) (we) last saw the deceased alive on 1/15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Felipe M. Dominguez, M.D. | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
1/15/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
FELIPE M. DOMINGUEZ, M.D. | | | 22e. ADDRESS
E.S.S. HOSPITAL, CAMBRIDGE, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
1/17/1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
FAMILY CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
WINGATE, DOR. MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR
ANTHONY P. LeCompte, Cambridge, MD. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
JAN 19 1968 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A75 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Curtis</i> | | | First Middle Last <i>Wolff</i> | | | 2a. DATE OF DEATH <i>Jan. 27 - 1968</i> | | | 2b. HOUR <i>2:40</i> AM |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>Nov 8 1880</i> | | | 6. AGE (In years last birthday) <i>87</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Dorchester</i> | | | Md. |
| 10. CITY OR TOWN OF DEATH <i>Hurlock Md.</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Belle Haven Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Dorchester</i> | | 13c. CITY OR TOWN <i>Rhodesdale</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>R.F.W.</i> | |
| 14. FATHER'S NAME First Middle Last <i>Phillip Wolff</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Malsena Talbot</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>217-361177</i> | | 17. INFORMANT <i>Norris Wolff - Rhodesdale, Md.</i> Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Influenza Asian proven by titre</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Arteriosclerotic Cardio renal Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Generalized arteriosclerosis</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 days</i>
<i>10 yrs</i>
<i>25 yrs</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Benign Prostatic Hypertrophy Nutritional anemie</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-19</i> , 19 <i>68</i> , to <i>1-27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-25</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Harold B. Plummer</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <i>1/29/68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Harold B. Plummer M.D.</i> | | | | 22e. ADDRESS <i>Preston Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1-29-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Galestown</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Galestown Dorchester Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Maurice A. Newman & Son</i> | | | | ADDRESS <i>Shantown, Md.</i> | | 25a. REC'D BY REGISTRAR DATE <i>FEB 1 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|---------|--|--------|---|---|---|-------|---|------|---|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | Month | Day | Year | 2b. HOUR |
| Nathaniel | | | | Young | Jan. 2 1968 | | | | | 9:45 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
HOURS | MIN | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| Male | Negro | April 8, 1926 | | 41 YRS. | | | | Jan. 2 1968 | | 10:30 AM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Md. | | USA | | | | Dorchester Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cambridge | | Phillips St. | | | Laborer | | | General | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md. | | Dor. | | Cambridge | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 700 Phillips St. | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | |
| Henry Young | | | | Sarah Blake | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | Md. | | |
| Yes | | WW 2 | | 218-16-7759 | | Lroetta Young 1014 Pine St. | | Cambridge | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fatty degeneration liver</u>
<u>571.8</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Coronary sclerosis</u>
(c) <u>Pulmonary emphysema</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
?
?
? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>581.0</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Mace Jr.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) John Mace Jr. M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 1/23/68 | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Cambridge, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | | 1/6/68 | | Bethel Cemetery | | Cambridge, Dor. Md. | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Ludwig C. Blair | | | | Cambridge, Md. | | | | DATE JAN 30 1968 | | Charles Judge |

10-10-10

10-10-10